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the impact of the joint crisis plan intervention**

Farrelly, Simone

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***Therapeutic Relationships in Community Mental Health
Settings: The Impact of the Joint Crisis Plan Intervention.***

Simone Farrelly

Thesis submitted for the degree of Doctor of Philosophy

School of Health Service and Population Research

Institute of Psychiatry
King's College London

2012

Abstract

Policy and professional guidance in England have emphasised the importance of Therapeutic Relationships (TRs) in community mental health care, yet there is no comprehensive model to guide practice or understand the process through which stronger TRs are generated. This thesis investigated TRs in community mental health for individuals with psychotic disorders and was embedded within the CRIMSON trial: a randomised controlled trial of the Joint Crisis Plan (JCP) intervention. JCPs contain service users' treatment preferences for future care, which are jointly decided with clinicians. Qualitative analyses addressed participants' views of TRs and JCPs. Quantitative analyses addressed the predictive utility of TRs for outcomes, associations of TRs and the effect of JCPs on service user and clinician-rated TR. Results suggested that significant ambiguity persists regarding what can and should be provided in community mental health, resulting in unhelpful experiences for service users and clinicians. A new model of TRs – *Consistent Respect* – was developed; it presents TRs as bi-directional processes, jointly affected by clinicians' and service users' experiences of interactions and their roles defined by the wider context; the latter often being a barrier to the development of strong TRs. JCPs significantly improved service users' appraisals of TRs by providing a structured protocol through which routine role enactments were limited and clinicians could demonstrate *Consistent Respect*. Positive effects were lost when there were deficiencies in the implementation of JCPs and/or engagement of clinicians. In conclusion, improving TRs through JCPs could facilitate better outcomes and more satisfactory treatment experiences for service users and clinicians. Changes in policy and practice are indicated to facilitate transparent goals and roles for clinicians and respectful interactions with service users.

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Use of abbreviations

- A&E: Accident and Emergency Centre
- AD: Advance Decision
- AS: Advance Statement
- CC: care coordinator/named clinician/keyworker
- CIS: Critical Interpretive Synthesis
- CPA: Care Programme Approach
- CPN: Community Psychiatric Nurse
- CTO: Community Treatment Order
- EBM: Evidenced based medicine
- EBP: Evidenced based practice
- GTM: Grounded Theory Methodology
- HAS: Helping Alliance Scale
- JCP: Joint Crisis Plan
- Manc/Lanc: Manchester/Lancashire
- MCA: Mental Capacity Act
- MHA: Mental Health Act
- MHS: Mental Health Services
- NHS: National Health Service
- QOL: Quality of Life
- RA: Research Assistant
- SDM: Shared Decision Making
- SI: Symbolic Interactionism

- SR: Systematic Review
- SU: mental health service user
- TAU: Treatment as usual
- TR: Therapeutic Relationship
- UK: United Kingdom
- USA: United States of America
- VW: Vocational Worker
- WAI: Working Alliance Inventory

'Only by taking on an air of bonhomie and a tone of extreme frankness can one penetrate into their inner most secret thoughts, clear up their anxieties and deal with apparent contradictions by comparing their problems to those of others'

(Phillipe Pinel, 1801)¹

'The development of a constructive therapeutic relationship is crucial to assessing accurately the nature of an individual's problems and provides the foundation of any subsequent plan of management.'

(NICE guidelines 2009)²

'Some of them [clinicians] treat you like you're garbage because you have got this illness, they think we're thick, we're not human beings. We have got illnesses, but we're not garbage and we do understand we're poorly.'

(Service user, CRIMSON Trial 2010)

1. Introduction

The Therapeutic Relationship (TR) between mental health service users (SU) and the individuals who provide this service is now seen as an essential underpinning of a successful interaction in psychiatry.³⁻⁵

Additionally, SUs identify the quality of the TR with service providers as a key component of good psychiatric care.^{6;7} Despite the popularity and face validity of the TR, significant conceptual confusion persists. There is no commonly agreed definition^{4;8} or clear understanding of the components of TRs and the importance of context is still unknown. Such issues make interpretation of research difficult and raise questions about the application of the concept in contexts other than psychotherapy. With recent policy directives calling for a more 'person-centred' approach to mental health service provision,⁹ an investigation into TRs within community mental health settings is timely.

1.1. Structure of the thesis

This thesis has two main aims and thus two parts. Part I describes the concept of TRs for individuals with severe mental illness, how this has changed over time, and how TRs are understood and measured currently. Part II describes the collection of new data that investigated TRs in community mental health currently and the impact of a crisis planning intervention on these relationships. The specific objectives are presented in Section 1.2 and the approaches used to address these are described in Section 1.3.

1.2. Summary of aims and objectives

The aim for Part I was to understand how TRs have been described and understood historically. The specific objectives were to:

- 1.1. Describe the historical developments of the concept of TRs in treatment and policy.
- 1.2. Determine the current level of evidence for an association between TRs and other variables including outcomes.
- 1.3. Analyse current understanding and assumptions in literature regarding the barriers and facilitators to TRs.

The aim for Part II was to investigate current views regarding the TR and understand the impact of the Joint Crisis Plan (JCP) intervention. The specific objectives were to determine:

- 2.1. How key stakeholders view and understand TRs in community mental health settings, and the barriers and facilitators to the development of strong TRs.
- 2.2. If the JCP intervention affects TRs and if so how?
- 2.3. If the TR at baseline was linked with outcome at follow-up.

1.3. Approaches used

In Part I, three approaches were used to capture understandings of the concept of TRs and how this has changed over time. Chapter 2 is a

narrative summary of the historical context. Development of the concept of TRs is tracked from the asylum era in mid 18th Century to the beginnings of the deinstitutionalisation movement in the mid 20th Century. Major policy and legal developments that led to the development of community mental health care are then discussed. In Chapter 3, two systematic reviews of quantitative literature are presented to describe the current evidence base for predictors and outcomes of TRs for individuals with psychotic disorders treated in community settings. Chapter 4 captures current understanding of the concept in community mental health by conducting a Critical Interpretive Synthesis of the literature. This qualitative synthesis technique illustrates how implicit assumptions and understandings are displayed through the literature. The final chapter of Part 1, Chapter 5, describes one of the key interactions of community mental health and the window through which the TR in this thesis is examined – clinical decision making and care planning, in particular the JCP intervention.

In Part II, to address the first two objectives (2.1 and 2.2) a mixed methods approach was employed. Mixed methods can be defined as the use of both qualitative and quantitative methods to generate a deeper and broader understanding of the phenomenon of interest^{10;11} than could be achieved with one approach alone. The findings of both qualitative and quantitative analyses were integrated to establish a deeper and broader understanding of TRs and the impact of the JCP intervention. The rationale behind the mixed methods approach and a detailed description of the quantitative and qualitative methods, including their sequencing and integration, is described in Chapter 6. Chapters 8-10 present the results of the qualitative analysis using a Constructivist Grounded Theory approach for each stakeholder group (SUs, Care Coordinators (CCs) and psychiatrists). Chapter 11 details the development of a new model of TRs based on the qualitative analyses. Quantitative analyses, and the integration of the quantitative and qualitative work, are presented in Chapter 12. The final chapter involves a summary of this work and the implications for the future in terms of policy, practice and research.

1.4. Theoretical background

This thesis takes a broad Social Constructivist perspective. Social Constructivism¹² proposes that our understanding and definitions of concepts such as the TR, are shaped by social factors including interactions, changing attitudes, increasing technology and policies. By describing the historical developments and changes in TRs, it will be shown how the understanding, focus and delivery of TRs has been informed and constructed by wider meso level factors associated with psychiatric care. For example, in the 1960s policy directed Mental Health Services (MHS) to provide social support, but in the 1990s this changed to social control; the TR was therefore understood in that way. In this context, current understanding of and barriers to the TR may also change in time. In addition, the theory of Symbolic Interactionism (SI)¹³ informs a great deal of this thesis. SI suggests that individuals' understandings of themselves and their place in the world is determined by interactions with others and the interpretations they make of those interactions. In recent times some have criticised SI for failing to take wider structural/societal factors into consideration.¹⁴ However, there have been variations of SI, such as Structural SI,¹⁵ that have incorporated contextual determinants of interactions. By combining the historical approach and Structural SI, this thesis considers not only the within and between individual determinants of relationships but the wider influences and contextual factors that influence these.

1.5. Definition of terms

When discussing the TR, a range of terms is used, often inconsistently. Most commonly, it is discussed as the 'therapeutic relationship', the 'therapeutic alliance' or 'working alliance'. However these terms have different etymologies, connotations and may in fact, be components of the same construct.

The Oxford Dictionary defines *alliance* as a 'state of union or combination' or 'people united by kinship or friendship, kindred, friends or allies.'¹⁶ It is generally used to denote a sense of being united with another for a defined

purpose and has a sense of equality, and being advantageous to all parties. Alliance implies a sense of agreement, but not necessarily an emotional connection such as being liked or trusted. In terms of community MHS, *alliance* would imply a voluntary union, sought by both parties; something which is often not the case. In this context, 'therapeutic alliance' and 'working alliance' will not be used in this thesis.

Conversely, the Oxford Dictionary defines *relationship* as 'the state of being related; a condition or character based upon this; kinship' or the '... particular way in which one thing is thought of in connection with another'.¹⁶ In this way, a relationship could be a passive connection between parties. It does not necessitate a conscious, purposeful connection nor does it imply a common cause or outcome. It may include notions of alliance (as described above) and positive or negative emotional connections (e.g., trust or distrust). In MHS, the term may therefore more adequately describe the connection between a SU and a service provider, in particular when it is one that is not voluntarily sought.

Therapeutic is defined as 'of or pertaining to the healing of disease' or 'to minister to, treat medically'.¹⁶ Therefore, *therapeutic relationship* could denote a union with a defined endpoint of curing mental illness or an interaction that is defined around treatment (without reference to the endpoint). In this thesis, the latter sense will be used. That is, rather than suggesting a curative function, the term 'Therapeutic Relationship' will be used to describe a connection and interaction between SUs and clinicians that is defined through treatment.

There is additional conceptual confusion¹⁷ about the term which has led some authors¹⁸ to make a distinction between 'interaction' and the 'relationship'. An *interaction* is an objective and observable behavioural exchange between individuals. The *relationship* is a psychological construct held by both individuals regarding the interaction and the other individual – it may therefore be seen as an appraisal.

In summary the term 'Therapeutic Relationship' (TR) will be used throughout this thesis to denote:

'an appraisal of the connection and interaction between SUs and clinicians that is defined through the delivery of mental health treatment'.

1.6. Statement of work

This thesis used data collected from the CRIMSON trial. The author of the thesis was the full-time Scientific Coordinator for the CRIMSON trial and completed this thesis part-time. The CRIMSON trial was designed by the management team (listed in the Acknowledgments section).

As the CRIMSON Coordinator, the author developed the trial protocol, obtained ethical and other governance approval, recruited and trained research and clinical staff, and oversaw the collection of quantitative data by Research Assistants (RAs) and delivery of the intervention by clinicians. The author personally conducted the qualitative component of the CRIMSON trial and this thesis which involved: altering the design, gaining ethical approvals for amendments, designing topic guides, recruiting participants, conducting all focus groups and individual interviews and doing all of the analysis. In terms of the quantitative analyses, the power calculation was conducted by the trial statistician. All other analyses presented in this thesis were conducted by the author.

Part I

2. Background of concept of Therapeutic Relationships

2.1. Introduction

This chapter aims to describe the genesis and refinement of the concept of TRs in the treatment of SUs. There are three main sections to this chapter:

- Firstly, the refinement of the concept of TRs from the 18th century will be traced, noting how variations in the understanding of the aetiology of mental illness and dominant treatment methods have affected its definition and perceived importance;
- Secondly, the major policy developments in the UK that have influenced the practice of community mental health treatment will be outlined;
- Finally, major models of TRs from psychology will be described.

In taking such an approach, one can see that while the TR has at times been considered the 'vehicle for success'³, (i.e., curative in and of itself), emphasis on the TR has varied depending on the dominant model/understanding of mental illness, attitudes of the public, and technological advances in other treatments such as psychotropic medication. Furthermore, for a TR to be possible SUs require a certain status to be able to interact and appraise clinicians; this has not always been the case. The result has been that, particularly in the context of community treatment of individuals with psychotic disorders, the TR has been poorly defined and operationalised, often resulting in variable and disappointing treatment experiences for SUs.

2.2. History of Therapeutic Relationships in the treatment of mental illness

Despite the development of organised strategies to care for the 'insane' by the 14th Century,¹⁹ the first clear delineation of the concept of TRs did not occur until the early 20th century. This is not surprising as the 'insane' had been likened to criminals, devils, fools and animals or an 'absence of

humanity'.¹⁹⁻²¹ Madness was believed to be incurable and therefore sufferers were 'confined' rather than treated.²⁰ It wasn't until the late 18th and early 19th centuries, that care of the insane came to the attention of medically trained practitioners,^{19;20} and the focus shifted from containment to the possibility of treatment or therapy.

In this section, the major trends in the treatment of severe mental illnesses from the late 18th century will be described. There are three main parts:

- The optimism and treatment model associated with asylum based care in the late 18th Century, and in particular, the development of Moral Treatment.
- The rise of 'talking therapies' in the early 20th Century through which ideas about the healing power of the TR were refined.
- Investigations into the deleterious effects of the asylum and a re-orientation to the therapeutic benefits of the interactions between clinicians and patients.

2.2.1. The curing power of asylums

In 1750, William Battie, in his '*Treatise on Madness*',²² was one of the first physicians to propose a treatable form of madness.¹ Battie distinguished 'consequential' insanity from 'original' insanity, the former being curable through close 'management' or a process of individualised care that focused on specific symptoms. Battie's proposition, which placed importance on the interaction between the physician and patient, could be seen as the genesis of the concept of the TR.

Following Battie in the late 18th and early 19th centuries, 'Moral Treatment' (moral meaning 'mental'¹) as practiced by William Tuke at the York Asylum in the UK and by Pinel at Bicetre in Paris, was an attempt to exploit the interaction between the patient and the care providers.^{19;23;24} At this time insanity was viewed as a product of dysfunctional environments; treatment therefore involved exposure to a more adaptive model of community and relationships.²⁶ Moral Treatment encouraged interaction between patients

and clinicians; interactions through which patients could learn correct behaviours, with clinicians as their guide. In 1801, Pinel wrote,

*'Patients normally try to conceal from one what they're thinking. Only by taking on an air of bonhomie and a tone of extreme frankness can one penetrate into their inner most secret thoughts, clear up their anxieties and deal with apparent contradictions by comparing their problems to those of others.'*¹

Patients who exhibited 'good' behaviour were praised and rewarded; those who did not were punished or admonished. The hypothesis was that the disapproval of clinicians would be a catalyst for change. Moral Treatment was therefore an explicit manipulation of the interaction between doctor and patient.

The movement to more psychological approaches reflected a broader trend towards considering madness a disorder of the psyche rather than an inheritable, incurable disease. Madness became a disorder that could be observed and possibly cured through close interaction with a suitable professional. This optimism at the end of the 18th Century accompanied a belief that asylums were the ideal place to enable such close observations and interactions, and may, themselves, be curative.¹ Indeed, initial statistics provided a strong rationale for this optimism, however by the end of the 19th century, cure rates dropped, most probably the result of burgeoning patient numbers and a diminished ability of doctors to provide sufficiently personalised care.^{19;27;28} Such were the vast numbers of patients held within asylums, regular individual contact between clinicians and patients was impractical and asylums became places where patients were 'warehoused'.^{1;26}

Around the same time, with increasing sophistication of medical investigations, the pendulum swung away from a belief in the therapeutic benefit of interactions, and back to the idea that mental illness was inheritable, incurable and degenerative.^{19;26} At the beginning of the 20th century, psychiatry could broadly be seen to split into two streams: confinement in asylums for individuals with psychotic or severe disorders;

and treatment of individuals with less severe, 'nervous' or neurotic conditions with talking therapies.

2.2.2. The rise of talking therapies

Building on the theories and practices of Moral Treatment, the proponents of talking therapies hypothesised that patients would be helped by talking with a clinician about their emotions and experiences. This movement is best known to have been led by Sigmund Freud and psychoanalysis. However, there were other theorists working 'psychotherapeutically' with patients prior to Freud. One of the lesser known but influential practitioners was Paul Dubois.

2.2.2.1. Persuasion

In 1904, Paul Dubois published '*The psychic treatment of nervous disorders: The psychoneuroses and their moral treatment*³⁰' and advocated a rational approach to treating patients. Working with neurotics, Dubois described an approach that could be seen as the precursor of Cognitive Therapy (see 2.4.3). Dubois believed irrationality was the cause of neurosis and proposed gentle and supportive questioning of the patient's thought processes, actively pointing out illogical assumptions or conclusions. He sought to teach the patient to examine their own thoughts for a lack of logic or rationality. Dubois wrote of the necessary bond between the doctor and patient that was required to undertake this work,

'It is necessary from the very start that he should establish between them a strong bond of confidence and sympathy. Even at the first interview this relationship must be decided upon... The patient should immediately feel that the physician does not regard him only as a "client," nor only as an "interesting case," but that he is a friend with no idea but to cure him. We practitioners ought to show our patients such a lively and all-enveloping sympathy that it would be really very ungracious of them not to get well...' (p226)

Dubois saw the doctor-patient interaction and bond not as curative in and of itself but rather the means through which the active work of 'persuasion' and 'influence' could be achieved. The doctor in this model was very much an authority figure, however the interaction was a friendly and personal one.

2.2.2.2. *Psychoanalysis*

Freud introduced the idea of the unconscious and of transference (that is the unconscious replaying of conflicts through 'transferring' the traits of others onto the therapist). Freud facilitated transference reactions and through interpretation of their reactions he believed patients could be cured of their distressing conditions. In 1912, he discussed the necessary conditions for establishing a transference reaction:

'It remains the first aim of the treatment to attach him (the patient) to it and to the person of the doctor. To ensure this, nothing need be done but to give him time. If one exhibits a serious interest in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment... it is certainly possible to forfeit this first success if from the start one takes up any standpoint other than one of sympathetic understanding'. (see ³¹)

Like Dubois, a TR characterised by sympathetic understanding and interest, was not curative but an important and necessary condition for successful analysis. Interestingly, and as opposed to Dubois, relationships with patients were formal and somewhat impersonal by today's standards. The interactions were largely paternalistic with the interpretations and 'work' done by the analyst. Sitting out of the patient's view, power rested solely with the analyst.³²

Moral Treatment practitioners, Dubois, Freud and contemporaries all saw therapeutic benefit in the interactions between doctors and their patients. Such principles were attempted in asylum based care,¹ but due to the vast numbers held within, the lengthy one-on-one interactions required of such approaches were not feasible. Instead, the early decades of the 20th century

saw rapid developments in physical treatments such as psychosurgery and insulin comas.^{1;19} While controversial by today's standards, there was some success with such treatments¹ and as such the interactions between doctors and patients were de-emphasised (but not forgotten) in this period. Many asylum psychiatrists practised a mixture of physical treatments combined with interpersonal methods such as reassurance, suggestion, advice and reproof.³³

2.2.3. 'Mortification of self' – asylum-based care 1930-1960s

During the first half of the 20th Century, there was increasing disquiet regarding the environment of asylums and the effectiveness of treatments offered. For example, J. Bockhoven, the Senior Psychiatrist of the Boston Psychopathic Hospital wrote in 1956,²⁷

'It is not until one enters the wards where the patients live that one feels the impact of what it means to be a patient in a typical mental hospital. Contrary to one's expectations, ward after ward may be passed through without witnessing the violent, the grotesque, or the ridiculous. Instead one absorbs the heaving atmosphere of hundreds of people doing nothing and showing interest in nothing. Endless lines of people sit on benches along the walls. Some have their eyes closed; others gaze fixedly at the floor or the opposite wall [...] All and all, it is an innocuous scene characterised by inertness, listlessness, docility and utter hopelessness. [...] The visitor may well feel restless and irritated by the apathy of the patients and their willingness to waste these hours of their lives in meaningless tedium. His irritation may lead to his asking questions. If so he learns that the attendant is proud of the ward because it is quiet and no mishaps have occurred while he was on duty; because the floor is clean; because the patients are prompt and orderly in going to and from meals. The visitor finds that the scene which appals him with the emptiness and pointlessness of human life is regarded by the attendant as good behaviour on the part of the patients.' (p167-68)

As this example illustrates, the experience of many patients in asylums during this era was far from satisfactory. In some ways, their experiences

were reminiscent of those from preceding centuries where patients were 'warehoused' rather than helped.³⁴ In this context, interactions with clinicians were limited to control and routine functions in which the patient had no or very limited status.

2.2.3.1. Institutions and Institutionalism

In the late 1950s, Medical Sociologist Erving Goffman spent time in mental hospitals in America and published his findings in *'Asylums'*.³⁵ In this work he introduced the notion of 'total institutions'. Goffman believed that many institutions, including mental hospitals, acquired certain characteristics including repetitive and dehumanising interactions. Routines that were originally designed to fulfil institution goals resulted in inhabitants losing their individuality and sense of self, for example, 'stripping' of personal effects, clothes and forced washing. Goffman believed such repetitive acts resulted in 'mortification of self'. Patients in such environments had no responsibility for looking after themselves, many had no possessions of their own and many had not seen themselves in a mirror for many years,³⁴ suggesting extreme depersonalisation. Isolated from corrective and normalising structures in the community, Goffman proposed that clinicians became desensitised to the human beings under their care, and acted in automatic ways. He states at the beginning of the book that he purposively took the patients' perspective – the unheard voice.

While he has been criticised for taking a middle class attitude³⁶ and reducing complex systems of behaviour to simplistic responses to social environments,³⁷ *Asylums* was hugely influential in the 'anti-psychiatry' movement. In focusing on the experiences of the patient within institutions, Goffman was a loud and articulate advocate for improving the status of patients.

Following the publication of *Asylums*, a number of studies investigated the environment of asylums and their impact on patients. Wing and Brown³⁷ examined the conditions of three hospitals treating females with schizophrenia. Conducted originally in 1960 and repeated in 1964, they

found that impoverished environments on the wards were strongly related to the clinical presentation of patients; when the hospital environment improved there was a noticeable improvement in symptoms. By far the strongest influence was a reduction in the amount of time spent in 'inactivity'. The authors concluded that,

'A substantial proportion, though by no means all, of the morbidity shown by long-stay schizophrenic patients in mental hospitals is a product of their environment.' (p 177)

They also investigated 'secondary impairments', most noticeably patient attitude to discharge. Factors such as apathy and social withdrawal had previously been considered by-products of the disease process; the realisation that such factors may actually be a result of the 'treatment' was one of the catalysts for the movement towards community care.³⁶

In summary, during the first half of the 20th Century, patients in asylums appear to have progressively lost status as individuals, preventing any meaningful interactions with clinicians and the development of helpful TRs.

2.2.3.2. Remembering Moral Treatment – Social Therapy and Therapeutic Communities

Writing of his time as the Medical Superintendent at Fulbourn Hospital in the 1950s David Clark ³⁸ wrote that:

'Those of us who changed and opened psychiatric hospitals in the 1950s learned about social therapy on the job. First we rediscovered the principles of early nineteenth-century care for the mentally ill - the principles called 'moral management' by Tuke, Pinel, Conolly and others. The founders of humane asylum management asserted that wards should be small, home-like and friendly; that there should be plenty of activity - both work and play - for the patients; that clinicians should work with the rational and responsible part of the disordered person and ignore or minimise the irrational; that coercion and restraint should be minimal; that there should be no violence, brutality, oppression or degradation. We relearned all those lessons in the fifties.'

In 'Social Therapy'³⁴ he proposed that the interaction between people and the environment of the institution were the key determinants of patient recovery.³⁸ It progresses from the work of Wing, Brown and Goffman by including the impact of clinicians as one of the key 'environmental' factors affecting patient wellbeing and thereby re-introduces components of the TR. In Social Therapy power imbalances were actively broken down: nurses and doctors didn't wear uniforms; clinicians were called by their first name; wards were unlocked. Clark addressed attitudes of 'old-fashioned' clinicians to build an environment that was actively working towards the rehabilitation of patients, rather than 'warehousing' them. Patients were enabled and asked to take responsibility for themselves and clinicians assisted this process. The ideas of Social Therapy were fundamental to the development of 'Therapeutic Communities'.

2.2.3.3. Therapeutic Communities – giving voice to patients

The term 'Therapeutic Community' was first used by Tom Main in 1946 to describe the work done with returning soldiers from World War II, and was further developed by Maxwell Jones at the Belmont Hospital. A form of Social Therapy and similar to systemic theories (see 2.4.5), the principle behind Therapeutic Communities was that patients' wellbeing was affected by all members of the environment including clinicians and other patients. The main philosophy was of open communication and, rather than passive recipients of care, patients took responsibility for their own and each others' well being.³⁹ The egalitarian nature of the interactions actively sought to break down hierarchical structures between patients and clinicians.³⁴ The model of Therapeutic Communities, therefore, was a definite shift from asylum based care and required a change in interactional styles firstly between clinicians and patients and secondly, within and between different professional groupings. For example, MacDonald and Daniels⁴⁰ wrote in 1956 of their experiences introducing a Therapeutic Community in a Colorado Hospital:

'A nurse in a Therapeutic Community is required to perform a role far different from the one to which she has previously been accustomed. She must be more flexible, less dependent on rules and regulations,

and above all she must be willing to enter into a much closer relationship with patients than formerly. In this new situation, her previous training may be a handicap rather than an asset.' (p148)

There was also a significant shift for psychiatrists within Therapeutic Communities. While still considered the leader of the team and ward, they were no longer the sole practitioner involved with the patient, nor were they able to make autonomous decisions. In his discussion of the running of Therapeutic Communities in Fulbourn Hospital in the 1960s and 1970s, David Clark admitted,

'I well remember how difficult I found it when the patients voted that I should reduce one man's sedation - a great trespass on the prerogatives of the doctor. It turned out they were right; I did reduce the dosage and his disorder did improve. These experiments challenged the roles of all on the ward, but especially the authority of the doctor and the charge nurse'. ³⁸

Social Therapy, and specifically Therapeutic Communities, was a key progression in the delineation of TRs in mental health treatment for two reasons. Firstly, rather than seeing the patient as an object to be acted upon in a uniform way by professionals, the movement emphasised the expertise of individual SUs meaning that for the first time in hospital based care patients were included in treatment decisions and that their concerns were listened to and respected. Secondly, the impact of clinicians on the wellbeing of patients was actively considered, requiring clinicians to reflect on their practice and to consider elements of their personality, professional demeanour, or communication style.

In summary, this section began with a brief summary of Moral Treatment in the early 19th Century which emphasised warm and respectful interactions of patients and clinicians as the mechanism for change. Throughout the subsequent centuries, and with increasing sophistication of physical treatments, interactions between patients and clinicians were de-emphasised. However, in the last decades of the asylum era in the 1950s and 60s, when developments in physical treatments slowed and vast numbers of patients were detrimentally warehoused, clinicians returned to

the importance of interactions between patients and clinicians. It was at this same time that many psychological models of TRs were developed (see 2.4) and fed back into asylum based care. Despite such gains it was at this point in history, when there was a great push to close the asylums and move towards a system of care in the community.

2.3. Care in the community.

2.3.1. Introduction

This section outlines the legislation and policy that guided the closure of asylums and the delivery of care in the community in England from the 1950s to the present day. In particular, this section addresses changes within policy that provide a platform for TRs such as provisions for improving SU status and voice and overt references and definitions of TRs within in community treatment settings. There are three main parts:

- The period from 1950s to 1980s including changes to the Mental Health Act.
- The introduction and delivery of the Care Programme Approach that remains the cornerstone of the Government's mental health policy for England.
- Guidelines and policy from 2000 to the present day that provide a focus on SUs' experience of mental health care delivery.

2.3.2. 1950s to 1980s

In the 1950s the existent legislation was the 1890 Lunacy Act, which while revised, reflected an era with a different understanding of mental illness and its treatment. There was increasing public sympathy for the mentally ill that had risen since the world wars where many people had been exposed to veterans returning with mental health problems.^{28;41} Rather than the fault of the individual, mental illness was seen as a response to stressful situations and something that could be assisted with the proper treatment. In 1959 the Mental Health Act (MHA) was enacted; the most significant changes were: the provision for voluntary admissions i.e., an ideological change from long-term asylum stays; and the removal of legal input into

admission, thereby placing care of the mentally ill entirely in the hands of medical professionals. It was considered by many to be a progressive and enlightened piece of legislation⁴² which in part aimed to decrease the stigma of mental illness by presenting it as similar to other physical ailments.

2.3.2.1. Enoch Powell: the development of community care

In 1961, the Minister for Health, Enoch Powell, made a speech to the National Association of Mental Health Annual Conference that became known as the 'Water Tower' Speech. He suggested that asylums were representative of outdated assumptions of mental illness and advocated for their closure. It was followed in 1963 by '*Health and Welfare: the development of community care*'⁴³ which stipulated the purpose of MHS in the community was to:

'...help [patients] to live as nearly normal lives as the nature and extent of their disabilities allow. With suitable support and training, even severe disabilities can often be overcome sufficiently for the patient to become independent. Many will need some help through their lives; but the object is always to give each the utmost opportunity to develop his potentialities. Accordingly, the mental health services provide help in all the main aspects of ordinary life, in the home and at work.' (Paragraph 82)

This ambitious statement of purpose was consistent with the wider view of the time regarding the healing potential of the community.³⁹ The paper discussed the role of clinicians in the provision of MHS, for example, in Paragraph 83 it was stated:

'A normal person relies on those who he lives and works with for understanding, sympathy and cooperation. Where there is mental disorder these supports may be seriously undermined or even destroyed. The mental health services therefore aim at strengthening them or constructing others in their place [...]. Through personal contact the social worker can also establish what other services are appropriate and try to ensure that the mentally disordered and their relatives take proper advantage of them.'

It was an important statement of the potential for supportive care and emphasised the need for 'personal contact' between clinicians and patients. Additionally, by discussing social relationships patients began to be humanised and recognised as individuals with a right to normal experiences in the community. With the exception of the role of social support, there was no stated goal or depiction of the kind of therapeutic or clinical work to be undertaken; rather the emphasis was on rehabilitation through access and exposure to normative social structures.

2.3.2.2. 1970s - Hospital services for the mentally ill

Almost a decade later the 1971 '*Hospital services for the mentally ill*'⁴⁴ outlined the concept of a comprehensive integrated hospital and community service. As its name suggests, there was a heavy focus on hospital services, however it extended the themes and values of the 1960 policy documents regarding care in the community and reflected research findings into the nullifying effects of institutional life (see 2.2.3). It emphasised humane care, viewing patients as individuals with a right to privacy and individualised care in hospital and in the community. Importantly, it highlighted the importance of skilled clinicians and the relationships between clinicians and patients and, as such, had one of the first clear statements regarding the TR in government policy. For example Paragraph 9 states:

'The successful development of the comprehensive service outlined above depends very largely on the attitudes, ideas and initiative of clinicians and the way clinicians are organised. The aim is to provide the full range of treatment now available with as little interference as possible to the patient's ordinary way of life. It entails a flexible and comprehensive approach in which clinicians are able to make their skills and resources freely available to patients wherever they may be, whether in the ward, the day hospital, the outpatient department or at home. [...] After the patient's discharge from the hospital, the doctor, nurse or social worker who has developed a Therapeutic Relationship with the patient may need to be able to maintain this in the day hospital, outpatient clinic or on home visits.'

However, it is clear from research conducted at this time that this policy, and its predecessors, were overly ambitious and the reality of service provision at the time was something different. Baruch and Treacher, in their 1978 book *'Psychiatry Observed'*⁴⁵ described the provision of care in psychiatric units attached to general hospitals in the 1970s:

'...clinicians were effectively institutionalised – they rarely made domiciliary visits to their patients and they were not involved in the communities from which their patients came, so they could never develop an understanding of the patients' way of life or devise methods for using community resources to help the patients.' (p223)

It is surprising that, while some models of clinical practice, such as Therapeutic Communities, had been questioning and reflecting on the interaction of clinicians and patients, such a discourse did not happen at the policy level. Clinicians whose previous responsibilities had involved day to day supervision of medication, meals and hygiene, were expected to 'enable' and support independent living. It wasn't until the 1990s that such a discourse began.

2.3.3. Care in the community - the 1980s

In 1980, the government produced a consultation document called *'Care in Community'*.⁴⁶ It focused on the financial and organisational arrangements for helping people in the community. In many ways this document discussed community care as a hypothetical – something that was still achievable. The need for such a document 20 years after Powell's Water Tower speech clearly illustrates the logistical difficulties in providing community based care. It is perhaps for this reason that discussion of how, rather than what, services were delivered in community settings did not occur at the forefront of policy.

2.3.3.1. 1983 Mental Health Act

At the same time there were a series of scandals regarding the treatment of hospitalised patients.^{42;47} In response, amendments to the 1959 MHA were sought, particularly with reference to patients' civil and human rights. The National Association for Mental Health (MIND) was one of the key lobby groups.⁴⁷ In particular, an American lawyer called Larry Gostin was appointed as a legal rights officer and was particularly influential in establishing a focus on patients' civil rights.⁴⁷ Gostin focussed on the need for independent review of treatment decisions for which the patient did not consent. This was important for two reasons: firstly, the focus on patient consent provided the basis for viewing SUs as individuals with rights; and secondly it was a challenge to psychiatrists' professional autonomy⁴⁷ as the use of tribunals and social workers in treatment decisions was a reversal of the long trend to view mental illness as just like any other physical illness thus warranting medical expertise (see Section 2.3.2).

Following a long period of debate and various amendments,^{42;47} the ensuing Mental Health Act 1983 was passed. Its main changes were to introduce more rights for individual patients including:

- rights of representation at appeal;
- provisions enabling patients to appeal detainment at a tribunal;
- development of Approved Social Worker post to ensure the systematic consideration of social needs in decisions to detain;
- second medical opinion required where patients had not consented to treatment.

It has been criticised for having a limited impact and a focus on hospital based service when the focus of most stakeholders had been on improving community care.²⁶ However, the work from Gostin in particular represents an important shift in considering the rights of individual patients. For example, he wrote that the law should seek to:

'...alter the social perceptions of the Mental Health Services, which should place an emphasis on the person distressed and not on the concerns of society or the profession. Once this principle is accepted it follows that services should be provided as a right, according to the

*needs of the person and not at the discretion of the professional; a person's consent should be the operative factor and not what others feel would be in the individual's best interests; and the receipt of services should be for the benefit of the person and not to provide an automatic rationale for society to diminish the civil and social status of the individual.'*⁴⁸ (p67)

For the first time, discourse at the legislation/policy level overtly considered aspects of patients' experience of treatment, in particular with reference to consent and rights to appeal. In doing so, the groundwork was laid for considering the TR and the components required.

2.3.4. The Care Programme Approach – 1990s onwards

In 1988 the UK Government commissioned a review into MHS by businessman Roy Griffiths. The 'Griffiths Report' introduced the notion of the National Health Service (NHS) as a *service* and professionals as *service providers*. One of the key principles of such a consumerist model was that the people who received the service should have choice and influence over what services they received. As Rogers and Pilgrim²⁶ wrote:

'By unleashing consumerism, via marketisation, the government offered hope to people whose views were previously ignored by service providers: psychiatric patients.' (p77)

Following the Griffiths report, in 1989 the government produced a White Paper called '*Caring for people: community care in the next decade and beyond*'.⁴⁹ As part of this White Paper and ensuing Act, the 'Care Programme Approach' (CPA) was established. The key elements of the CPA were that each patient should have a formal assessment of their needs, an agreed care plan and regular reviews of both. As such, the CPA was an attempt to formalise SUs' involvement in their own care. Patients were appointed a keyworker to 'keep in close touch with the patient and to monitor that the agreed health and social care is given'.⁵⁰ As opposed to the relative emphasis in the 1971 '*Hospital Services for the Mentally Ill*', the

concept of a TR between keyworkers and SUs was given only a passing reference in Paragraph 19:

'Every reasonable effort should be made to maintain contact with the patient and where appropriate, his/her carers, to find out what is happening to seek to sustain the therapeutic relationship and if this is not possible, to try to ensure that the patient and carer knows how to make contact with his/her keyworker or the other professional clinicians involved.'

Despite specifying a key person to whom a patient would be connected, it was for the purpose of efficiency and continuity. No further information was given about the role, qualifications or capabilities of the keyworker.

2.3.4.1. Models of case management

By not emphasising the skills and expertise of the keyworker role, and through the emphasis on administrative functions, the CPA approximated a brokerage model. In a strict brokerage model, the keyworker does not need mental health expertise, rather the emphasis is on organising access to psychiatric care.⁵¹ There is little evidence for the benefits of such an approach^{52;53} and importantly, it takes the focus away from the potential beneficial interactions between clinicians and SUs, and thus the TR.

Other models of case management include: clinical case management; rehabilitation-oriented; and intensive case management models.⁵¹⁻⁵⁴ In clinical case management and rehabilitation-oriented case management the TR is emphasised, and therefore the case manager needs to be a skilled and knowledgeable mental health professional. Furthermore, both models take a reasonably holistic approach and address social supports and life domains outside of those specific to mental illness. In intensive case management, rather than individual relationships between a keyworker/case manager and SU, the clinical team takes responsibility for the wellbeing of reluctant or uncooperative SUs.⁵³ The focus of such intensive approaches tends to be medication compliance with clinicians often attending the SUs' home to ensure medication is taken.⁵¹

By inferring a brokerage model and through the lack of clearly articulated model of case management, the CPA lacked an overall framework to guide psychiatric treatment,⁵¹ and de-emphasised the TR.

Interestingly, in the early 1990s, there was at least an ideological gap between policy makers and clinical academics, with the latter emphasising the importance of TRs within this keyworker role^{55;56} indicating a policy and practice gap resulting from the lack of delineation of the tasks and skills required in the keyworker role.^{52;53;56}

2.3.4.2. Post CPA implementation research

In 1993, North and Ritchie⁵⁷ reported on the implementation of the CPA. They found that the lack of central guidance on the keyworker role resulted in local services developing their own definition. In many cases, clinicians reported maintaining the model of case management they implemented prior to the CPA's introduction. SUs and carers reported marked variation in the input from keyworkers. Other research suggested that the variation in practice continued in the late 1990s, yet the core administrative aspects of CPA (assessment, care planning and reviews) were more routinely implemented.⁵⁸ Research on SUs' experiences suggests that they were seen infrequently, and most didn't know if they had a keyworker nor were they involved in care planning.^{59;60} A review of progress by the Social Services Inspectorate in 1994⁶¹ indicated that there was '*little evidence of use of the CPA as a framework for care planning*' (Paragraph 1.4).

By 1998 a further investigation by the Social Service Inspectorate⁶¹ found improvements in the understanding of the CPA, collaborative working between different departments and '*extensive involvement of users and carers in care planning*' (Paragraph 1.8). This latter statement, however, seems to be contradicted by the finding that 67% of users were invited to meetings and by the admission that:

'Users too frequently found participation difficult because the meeting was conducted in a formal manner, with a number of people present that they did not know. At times carers found it frustrating when meetings were not given a specific time. This preventing them from

attending because of difficulties in making caring arrangements for other family members. Often the meetings were arranged at the convenience of medical clinicians.' (Paragraph 1.31)

Despite assurances that the CPA was not a bureaucratic system,⁶¹ in many cases it was experienced as such by clinicians.^{56;62} Auditing and reviews of the CPA focused on administrative issues with no mention of SU satisfaction with care or clinician/SU interactions other than the inclusion of SUs in care planning (also see Section 5.2). Such assessment of the CPA took services further from focusing on how services were being delivered and whether they were satisfactory to SUs, or indeed effective. As Diana Rose has stated, '... it is clear that coordinated care could proceed without involving users at all.'⁶³

2.3.4.3. Concerns in the community

In the mid 1990s a number of high profile cases suggested serious failings in the implementation of mental health care in the community, leading to wide spread concern about public safety.^{26;64} Newspapers responded with a series of emotive headlines such as '*Free mental patients kill two a month*' (see ⁶⁴). Most prominent amongst incidents was the killing of Jonathon Zito by Christopher Clunis, a young man with a diagnosis of schizophrenia.⁶⁵ A report indicated failings of individual practitioners and service agencies to ensure continuity of care and monitoring for Clunis. The widow of Zito subsequently set up the Zito Trust whose stated aim was to support victims of failures in community care service provision,⁶⁴ and campaigned widely for more effectively coordinated services. It has been argued that such high profile campaigning and the media coverage of such events, have been influential in delivering more restrictive MHS.⁶⁴ There is no doubt that the Clunis case and others captured the public's imagination, but it would be too simplistic to propose a direct linkage to changes in government policy. During this period in the 1990s and arguably still today, there was a wider societal move towards greater conservatism and relatively extreme aversion to risk or a 'culture of fear',⁶⁶ and a government perceived imperative to be seen to be dealing with such risk. Combined with the difficulties experienced in implementing community care, and a continued focus on

improving efficiency of services, there was a marked change in tone of mental health policy. A prominent sociologist stated at the time:

*'The task for the psychiatric profession is now less therapeutic than administrative: administering problematic persons in the complex terrain [of the 'community'] in an attempt to control their future conduct.'*⁶⁷

2.3.4.4. *The 'failure' of care in the community and 'The Modernising Agenda'*

In 1998, the newly elected Labour Government published *'Modernising Mental Health Services: Safe, sound, and supportive'*⁶⁸ with a Foreword by the Secretary of State, Frank Dobson, who infamously stated that:

'Care in the community has failed because, while it improved the treatment of many people who were mentally ill, it left far too many walking the streets, often at risk to themselves and a nuisance to others. A small but significant minority have been a threat to others or themselves.'

He went on to state that his government would ensure:

'...that patients who might otherwise be a danger to themselves and others are no longer allowed to refuse to comply with treatment they need. We will also be changing the law to permit the detention of a small group of people who have not committed a crime but whose untreatable psychiatric disorder makes them dangerous.'

Like policy documents before it, *Modernising Mental Health Services* focused on provision of care. However, in a noticeable break from previous policy, and in direct conflict with the ideology espoused by Gostin (see 2.3.3.1), pre-emptive strategies to control and contain SUs were emphasised. This policy moved beyond the medicalisation of mental illness as a strategy for combating discrimination (see 2.3.2) to a form of medicalisation (through enforced care plans) that could be seen as discriminatory.⁵⁶ In this context, clinicians' roles became less about helping patients to *'live as nearly normal lives as the nature and extent of their disabilities allow'*⁴³ to becoming more custodial,⁶⁷ thereby establishing a statutory barrier between SUs and

clinicians. The policy prioritised the perceived needs of people who were not direct recipients of the service i.e., the 'public'. In the name of modernising services, this policy arguably took the tone and values of mental health policy back more than 30 years, through the focus on the threat to the community rather than improving care standards for SUs.^{26;67;69} Not surprisingly, there was widespread concern regarding its impact.^{56;67}

Despite the 'failure', the Government reiterated its commitment to the CPA in '*Effective Care Coordination in MHS*' (1999).⁷⁰ Of the four sections of the paper, the first three were about service provision and efficiency, and the fourth was entitled 'achieving a proper focus on the needs of SUs'. Under the latter, the first guideline was about risk assessment and management. As one clinician wrote at the time,

*'There is a very real danger that community mental health teams, as the vehicle for care management and the [CPA], are seen to perpetuate the medicalisation of difference and the denial of dignity and choice that often characterised institutional care.'*⁵⁶

2.3.4.5. National Service Framework

In 1999, the Government also published the National Service Framework for Mental Health (NSF)⁷¹ to articulate national standards for MHS, their development, goals and assessment. The NSF set standards in five areas:

- Standard one: Mental health promotion
- Standards two and three: Primary care and access to services
- Standards four and five: Effective services for people with severe mental illness
- Standard six: Caring about carers
- Standard seven: Preventing suicide

The guidance focused on care planning and reviews – key elements of the CPA. Importantly, there was an emphasis on involving SUs in these plans and reviews, but no clear guidance for assessing this. In its 158 pages, the terms 'TR', 'therapeutic alliance', 'relationship' (between SU and clinicians), and 'therapeutic' are used 0, 1, 1 and 1 times respectively. By contrast, 'relationship' (between different service providers) is used 5 times and 'risk'

is used 97 times. Typical of previous policy it focused on service provision. It was a necessary and influential document, yet one that missed an opportunity to guide services towards focusing on SUs' experience of services through emphasising the importance of the TR and alleviating symptoms, as opposed to alleviating risk.

2.3.5. Giving voice to service users: 2000s to present day

2.3.5.1. Mental Capacity Act and 2007 Mental Health Act

The 2005 Mental Capacity Act (MCA)⁷² was implemented in 2007 and is still current. It aimed to protect individuals who cannot make decisions for themselves. It has a broader applicability than MHS, but in some ways, it could be interpreted as an extension of Larry Gostin's work in that it provides guidance for both clinicians and SUs regarding treatment decisions when SUs may or may not consent to treatment. In simple terms, the MCA helps stakeholders to determine when a SU has capacity to make a decision and when they do not. There are five key principles:

- Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- People must be supported as much as possible to make a decision before anyone concludes that they cannot make their own decision.
- People have the right to make what others might regard as an unwise or eccentric decision.
- Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.
- Anything done for, or on behalf of, people without capacity should be the least restrictive of their basic rights and freedoms.

The MCA stipulated that a person is unable to make a particular decision if they cannot do one or more of the following things:

- Understand information given to them.
- Retain that information long enough to be able to make the decision.
- Weigh up the information available to make the decision.

- Communicate their decision - this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

Additionally, the MCA provided a legal framework for refusal of medical treatment. In the MCA, an *Advance Decision* is a refusal of specified treatment or medication (see Section 5.4.6.1). In these ways, the MCA was a very important piece of legislation due to the focus on SUs' right to autonomy.

In 1998 the Government announced its intention to review the 1983 MHA, however, it was not until 2007 that these changes were enacted – perhaps an indication of their controversial nature.⁷³ Amendments included changes to the approved and responsible clinician roles, ability for SUs to determine their nearest relative, and importantly, legally binding provision for SUs to refuse electro-convulsive therapy. The most controversial change, however was the provision of Community Treatment Orders (CTOs), which enable a clinician to recall a SU to hospital if they do not comply with treatment. This was enacted despite a lack of evidence for their effectiveness.⁷⁴ The extension of clinicians' powers, could be seen as a contradiction of the gains of the MCA by reducing SUs' autonomy, thus creating confusion and ambiguity.

2.3.5.2. *Guidance on Therapeutic Relationships from the Royal College of Psychiatrists*

In 2007, the Royal College of Psychiatrists published guidance on clinical relationships with vulnerable patients.⁷⁵ Several important principles were outlined in this document which established a break with traditional hierarchies. For example, they recommended clinicians develop self awareness to '*disentangle what comes directly from the patient and what colours their reactions to the patients from their own attitudes, beliefs and expectations*'. Similarly, psychiatrists were encouraged to '*respect and encourage the patient's autonomy*' and be clear about which role they were playing with a SU, such as supporter, educator, advisor and advocate. They stated that:

'Therapeutic Relationships are founded on mutual respect. [...] Respect is developed over the stages of a relationship – the building up of trust, cooperative working on the problem and a healthy separation.'

Importantly, like Therapeutic Communities (Section 2.2.3.3) and Frank (described in Section 2.4.6) the guidelines described both the patient and clinician factors that may undermine the TR. This guidance was the first clear delineation of the TR as a bi-directional process and is arguably the most clear and realistic depiction of some of the determinants of TRs by either a government or professional body to date.

In 2009 the National Institute of Health and Clinical Excellence (NICE) published updated guidance of the core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.² In this guidance, the TR is emphasised and described as,

'... crucial to assessing accurately the nature of an individual's problems and provides the foundation of any subsequent plan of management.' (Section 2.5)

The guidance calls for sensitivity, establishment of trust, reliability, constancy, and collaboration as the core aspects of the TR and repeats some of the themes of the Royal College of Psychiatrists' guidance by including aspects of clinician and patient characteristics which affect the TR.

Both guidance documents represent a change in attitude in terms of: firmly establishing SUs as individuals with status and rights; recognising the impact of personalities and other characteristics of both clinicians and SUs and thereby humanising the interaction; and most importantly, giving priority to interactions and the TR in the successful delivery of community mental health care.

2.3.5.3. Refocusing the CPA

In 2008, the Government produced *'Refocusing the Care Programme Approach: policy and positive practice guidelines'*.⁹ In this document, the name of the keyworker role was changed to 'Care Coordinator' (CC).

Importantly, there was a significant shift in tone from 1998 and other predecessors as its focus was largely on the manner in which services were delivered, rather than what was provided. For example,

'[CPA] is called an 'approach', rather than just a system because the way that these elements are carried out is as important as the actual tasks themselves'. (p. 11)

The real impact of this guidance was the change in focus from the macro level of service provision to the relatively micro level of service delivery, namely the interactions between SUs and clinicians. For example the first value of the refocused CPA is:

'The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and a patient/service user second'.

'Refocusing the Care Programme Approach' advocated a 'person-centred' approach to the TR, characterised as:

'... shared listening, communicating, understanding, clarification and organisation of diverse opinion to deliver valued, appropriate, equitable and coordinated care. The quality of the relationship between the service user and care coordinator is one of the most important determinants of success.' (p7)

Additionally, in contrast to previous policy, it emphasised the importance of the CC role, recognising that successful performance required a constellation of different skills and capabilities. Around this time, a number of guidance documents (see ^{76;77}) further outlined some of the specific capabilities and skills required of mental health professionals.

2.3.5.4. Liberating the National Health Service

In 2011 the new Conservative Government set out proposals to reorganise the NHS. The subsequent '*Health and Social Care Bill*' has been enormously

controversial, however, one of the key principles of the bill is the notion of patient choice – that patients should be able to choose where and when they receive services. A consultation document called *'Liberating the NHS: No decision about me, without me'*,⁷⁸ described the Government's proposals for all patients, including mental health SUs. They proposed that:

'Patients should be at the heart of everything we do. In Liberating the NHS we set out the Government's ambition to achieve healthcare outcomes that are among the best in the world by involving patients fully in their own care, with decisions made in partnership with clinicians, rather than by clinicians alone.'

They promoted and defined shared decision making (SDM) as involving,

'...patient and their clinician(s) working together to clarify options and goals for their care, treatment and self-management, sharing information about those options and aiming to reach agreement on the best course of action. Shared decision-making is fundamental throughout the entire healthcare pathway irrespective of setting.'

The proposed model promotes choice at referral, in primary care, and before and after diagnosis. It is not clear, however, how choice is promoted and ensured in ongoing or long-term treatment such as those with chronic conditions nor how such an approach could be achieved while managing 'risk'. Nevertheless, it represents a further delineation in viewing SUs as consumers of a service (as intended by the Griffiths report and Gostin's work) with the resultant focus on rights and satisfaction. Should these proposals be enacted, SUs would no longer be acted upon, rather they would be active partners in decision making about their care. However, as will be described in later chapters, true patient choice and/or shared decision making is difficult to achieve in mental health care due to issues associated with risk and accountability. In this context, the TR comes into clear focus.

2.3.6. Summary

From this brief review, it is clear that the focus on service delivery and the lack of clear delineation of the model/goal of service provision has, until recently, worked against focussing on the TR in community mental health treatment settings. Furthermore, there has been a continual lack of clear definition of the model of case management and the keyworker/CC role⁵¹ which has resulted in a focus on the administrative and risk management components of service delivery rather than the TR. Recent emphasis on the TR and its components (such as person-centred practice) is a positive development, but as will become clear through this thesis, routine care in the community may not yet be achieving such aims (see Chapter 4 and Chapter 8).

2.4. Models of Therapeutic Relationships from psychology

In this final section of the Chapter, key theorists and therapies from psychology, which have influenced the way that the TR is understood today, will be briefly introduced.

2.4.1. 'Person-centred' therapy: modelling acceptance

A key figure in the development of psychotherapy and the theoretical delineation of the TR was Carl Rogers.⁷⁹ Rogers believed that individuals become distressed due to the introjection of other's evaluations and beliefs. Rogerian therapy focussed on helping individuals find their own sense of self worth and frameworks for understanding life. Roger's 'person-centred therapy' emphasised the therapist's responsibility in providing an empathic atmosphere and unconditional positive regard, rather than directing or suggesting change. As Rogers said,

'In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?'.⁸⁰ (p. 9)

Rogers described three conditions that were integral for such a relationship:

- 'unconditional positive regard', or 'a warm acceptance of and liking for the other person, as a separate individual',
- a genuine and transparent interaction where the therapist is true to himself, and
- the ability see the world and the client as the client does.⁸⁰

Rogers believed that with these three conditions, the client would find themselves in a supportive and accepting interaction which enabled them to learn self-acceptance and see opportunities for change. The therapist is non-directive and focuses on supporting the patient to achieve their potential. In fact, the 'therapeutic' work, or the mechanism of change in person-centred therapies is the TR itself, not the content of the discussions. Rogers stated:

'In such a relationship the individual becomes more integrated, more effective. He shows fewer of the characteristics which are usually termed neurotic or psychotic, and more of the characteristics of the healthy, well-functioning person. He changes his perception of himself, becoming more realistic in his views of self. He becomes more like the person he wishes to be. He values himself more highly. He is more self-confident and self-directing.' (p12)⁸⁰

'Person-centred' characteristics are considered core skills underlying most psychotherapies today and, as discussed above, recent policy has used this nomenclature to define the key aspects defining quality care.⁹ When used outside of Rogerian therapy, 'person centeredness' tends to refer to the emotional connection between clinicians and SUs that could be summarised as 'respectful'.

2.4.2. Behaviour Therapy: altering behaviours through collaboration

Developed by Hans Eysenck at the Institute of Psychiatry in the 1950s, Behaviour Therapy suggests that mental illness is a result of maladaptive responses to stimuli, responses that could be altered through careful examination and experiments.^{32;81} In Behaviour Therapy, the therapist teaches patients more effective behaviour and can therefore be quite directive. Patients are also active as they must be willing to experiment

with new behaviours. Behaviour Therapy does not emphasis the TR, but rather sees an interpersonal bond as enabling the therapist to make accurate assessments, and for the patient to trust and learn from the therapist.^{32;82} Often thought of as cold and mechanistic, Behaviour Therapy is rather a collaborative approach, built around goal-directed and structured techniques where the therapist acts as a consultant.⁸²

2.4.3. Cognitive Behavioural Therapy: 'co-investigators'

Cognitive Behavioural Therapy (CBT) is a combination of Behavioural Therapy, and Cognitive Therapy that was developed by Aaron Beck in the 1960s.⁸³ Cognitive Therapists believe that individuals learn maladaptive ways of processing information which lead to mental distress. Cognitive Therapists work with the client to develop new ways of processing and testing information.³² CBT combines the Cognitive and Behavioural Therapies by addressing maladaptive information processing through behavioural experiments designed to directly challenge the client's negative beliefs/thoughts. The TR in CBT aims to be collaborative, with the therapist acting as a co-investigator of the client's experience, and they work together to empirically test out hypotheses generated during sessions.^{32;81} The TR is not the core mechanism of change but a necessary ingredient in helping the client to achieve their goals.

2.4.4. Greenson's Working Alliance: 'co-workers'

In his 1967 book *'The technique and practice of psychoanalysis'*,⁸⁴ Greenson built on Freud's work on the TR by separating transference reactions and that of the 'real relationship' coining the phrase 'working alliance'. Unlike Freud, Greenson believed that the 'working alliance' was as important as transference in affecting outcomes and, in fact, could be seen as determining its success. He defines the working alliance as the 'relatively non-neurotic, rational rapport which the patient has with his analyst.' (p192). He chose the term 'working' to emphasise the patient's ability to work purposively in the therapy situation. Importantly, Greenson considered the relationship to be influenced by characteristics of both the patient *and* the therapist. The patient must be capable of self-reflection, communicating their thoughts and feelings, and partially regressing and

delving into transference reactions. The therapist, conversely, must be realistic, reasonable and humane exhibited through 'his compassion, his concern and his therapeutic intent toward his patient.' (p213)

With the concept of the patient as a 'co-worker' Greenson described a relationship where each party has an active role to play in an atmosphere of equality. This is reflective of other psychotherapy models of the time (e.g., collaborative working defined in Behavioural Therapies) and the wider social movement that questioned authority and aimed to empower individuals.¹⁹

2.4.5. Systemic therapies: treatable systems

Within systemic therapies the central hypothesis is that individuals are part of a system of intertwining relationships, such as families, and that the likelihood of affecting change is greater if people are treated within and including these systems. For systemic therapists, mental illness or distress is a result of, or is exacerbated by, interactional patterns within certain groups. Usually conducted within family settings the focus is on how communication and behaviours of members of the system reinforce maladaptive behaviours or interactions. With its theoretical basis in Behavioural Therapy, Family Behavioural Therapy has been used with some success for individuals with psychosis and has been shown to reduce relapse (see ⁸¹).

The TR in systemic therapies is quite different from traditional psychotherapy. Rather than a key agent of change, the therapist's role is to facilitate the system or group to change themselves. Therefore, in most systemic therapies, the therapist does not actively create a relationship with either the individual patient or other group members, but rather seeks to re-establish bonds or forge new patterns of interaction within the system; in this way their role is more marginal than in other psychotherapies.^{85;86}

2.4.6. Frank: individual characteristics determining Therapeutic Relationships

The models presented thus far describe the TR primarily in terms of an interpersonal bond, or atmosphere of warmth and empathy. However, the

characteristics of therapists and patients may be a barrier to the development of such a bond. Jerome Frank's 1974 book '*Persuasion and Healing*'⁸⁷ suggested that the success of therapy depends on the 'patient's conviction that the therapist cares about him' and further that 'is competent to help him' (p165). The notion of 'care' could be seen as an extension of Rogerian conception of 'unconditional positive regard', but the latter 'competency' is new. A patient's determination of a therapist's competency could be determined by many factors including: individual characteristics of the therapist; society's views of the profession; and indeed class and culture disparities. Frank also described how the individual characteristics of the patient, including class, education and adaptability, will impact on their engagement and ultimately what they receive from the therapy.

Frank described a bi-directional system with the patient's (not just therapist's) characteristics as a key component of the interaction. Where Rogers would suggest that regardless of the context and the individual characteristics of the patient, it is the therapists' ability to provide an environment for change that is the key factor in the success of the relationship, Frank introduces a systems-based understanding in which the therapist and patient influence each other bi-directionally.

2.4.7. Bordin's Goal, Task, Bond model

The final model of TR is Bordin's Pan-Theoretical Model.⁸⁸ Rather than a *mode* of interaction, Bordin's model outlined three key *components* of any interaction: Goal, Task and Bond. Bordin suggested that his Pan-Theoretical model was applicable to any context where change was sought. He proposed that agreement on the *Goal* of the interaction was a key task that underpins a successful working alliance. This agreement requires the patients to understand and agree that they are contributing to the 'problem' or 'pain' and are able to change their behaviours. The agreement requires the patient to concur with the therapist's theoretical persuasion and analysis of the core issues. Agreement on *Tasks* is the second component. Bordin described the development of a contract or an agreement of the specific tasks that patient and therapist will work on during the therapy. The tasks should have relevance, be communicated effectively, and reflecting Rogers,

be delivered with understanding to generate a collaborative working arrangement. The final component is 'Bond' and is 'intimately linked to the nature of the human relationship between therapist and patient' (p254). This includes notions of liking, trust, and attachment, Bordin suggested that 'some basic level' trust underpins all therapeutic interactions.

Bordin differentiated the type of bond developed or required between different types of therapeutic interventions through contrasting a behavioural intervention of filling in a form, versus an intervention where personal feelings and thoughts are shared and worked upon. Bordin suggested that one bond may not be stronger than the other but 'they do differ in kind' (p254). This seems intuitively correct and is perhaps highlighted in the different bonds developed between psychotherapist/client and CC/SU in community mental health, where pathways to, and tasks in care would differ markedly. Bordin's model does seem to apply to psychotherapeutic interactions where the patient generally seeks help and in many instances may choose the particular therapist and their method, but it is unclear the extent that this is generalisable to patients within community mental health settings where insight and willingness for treatment may be a problem.^{89;90}

2.4.8. Summary and applicability to community mental health

There are several differences between these models of TRs from psychotherapy. Firstly, there is variation in the emphasis placed on the TR. Rogers hypothesised that the TR is the agent of change, whereas most other models present the TR as the emotional connection which enables therapeutic work to be done. Secondly, the models differ regarding the form the 'bond' should take. Most advocate the Rogerian model of warmth, empathy and congruence, but some such as psychoanalysis and systemic therapies advocate maintaining a professional distance. Thirdly, the modes of interaction and role of the therapist differ from being entirely non-directive, to collaborative, and finally to being quite directive and authoritative.

None of the models outlined apply neatly to a community mental health setting. There are several issues. Firstly, all models discussed a shared view of the problem and thus help-seeking, however, mental health care in the community may not be voluntarily sought by SUs. Secondly, the level of intervention in the community can be different from psychotherapy. For example, SUs may be seen everyday in their home, they may be taken shopping, or helped with cleaning themselves and their homes. This differs markedly from weekly discussions in a therapist's office. In this context, professional/personal boundaries may be particularly porous; something which none of these models address. Thirdly, while there is often a key contact (i.e., CC), SUs treated in the community will interact with several members of a team, such as nurse, vocational worker and psychiatrist. In this context, models that discuss TRs in terms of a bond or agreement between individuals may miss an important aspect of the SU's experience. Finally, in addition to factors influencing the interactions between individuals, unique to community mental health are issues about public safety. Clinicians are required to 'care for' and 'control' SUs on their caseload. This dual role is not addressed and may prevent true collaboration and co-working proposed by the models from psychology. In this context, the importation of models developed in psychotherapy settings to community mental health settings is flawed.

2.5. Chapter summary

The working definition of the TR used in this thesis is:

- an appraisal of the interaction and other individuals connected through the delivery of mental health care.

The first section of this chapter illustrated how the TR has been part of mental health care since the late 18th Century, and has been used for therapeutic benefit, mostly notably through Moral Treatment. However, at various periods throughout this history, patients have been dehumanised to the extent that they may lack the status or capacity to interact with clinicians – thus preventing the TR. Additionally, fluctuations in attitudes, models of mental illness, and treatments available has meant that at times,

the TR has been considered the 'vehicle of success' and at other times, it has not been emphasised at all.

The second section illustrated how logistical and ideological difficulties in the delivery of community mental health treatment have resulted in only recent focus on the TR. The status of SUs as individuals with rights was not considered until the early 1980s and it was not until the early 1990s that policy documents formalised provisions for involving SUs in treatment planning. While there is no doubt that a range of practices were in place clinically, viewing SUs as active agents in policy was a significant development as it provided the basis for consideration of a TR based on respect and partnership working. Major policy documents have focussed on provision of care for individuals and there have been comparatively few references to what and how such aspects of care should be provided. As a result there is little guidance for clinicians^{51;90;91} and the focus of risk management appears to have worked against developing person-centred TRs in community mental health treatment settings (see also Sections 4.3.1 and 8.2.3).

The final section described major models of TRs from psychology and their different modes of interaction. While aspects of such models may be applicable to community mental health treatment settings, such as those described as person-centred, direct importation of such models do not capture the unique contextual impacts which may define the interaction. In this context, a model of the TR which considers such structural impacts is warranted.

In the next chapter, the effects of the ambiguous model of community mental health treatment will be illustrated in the presentation of the current evidence base for TRs.

3. Predictors and outcomes of Therapeutic Relationships

From the historical review in the previous chapter, it is clear that the TR has only recently become a focus of policy and professional guidance for community MHS in England. In this context research, in particular for individuals with severe mental illnesses (SMI) such as psychosis, has been minimal. Barriers to considering the TR for such patient groups other than the lack of policy include: speculation as to whether such individuals have the capacity to develop TRs;^{81;92;93} a concern that it takes a longer time to establish;⁹⁴ and that once developed the TR may not be as strong as other diagnostic groups (see ⁹⁵). Furthermore, a lack of clear evidence base may prevent prioritisation of the TR in the delivery of mental health care in the community.

There have been two meta-analyses which investigated TRs and outcome in *psychotherapeutic* settings. Horvath and Symonds⁹⁶ found 20 distinct data sets published between 1978 and 1990, that explored the relationship between 'working alliance' and outcome and found an average effect size of .26; a relatively small effect size but within the realms of other factors in psychotherapy. However, there was significant variability in samples, measures, outcomes and raters. Studies also investigated a range of different psychotherapeutic interventions including psychodynamic interventions, cognitive and Gestalt therapies; which may have very different goals, methodologies, and interactional components (see 2.4). The authors do not describe diagnoses of the patients in these studies which is a likely source of additional variability in the TR. Furthermore, the included studies used a range of measures to capture TRs including the Working Alliance Inventory (WAI) ⁹⁷ and other 'families' of alliance measures (see ⁹⁸ for discussion). A sub-analysis found significant differences in effect sizes across the measures, suggesting that the different instruments tap into different aspects of the concept.

A more recent meta-analysis by Martin and colleagues,⁹⁹ using the same entrance criteria for studies, reported on 79 studies published between 1978 and 1996 and found a similar effect size of .22. The authors

conducted several analyses which suggested that the overall effect size was not influenced by 'moderator' such as the variables discussed above including rater, measures and type of therapy. Neither review examined the influence of diagnostic category. Furthermore, the TR in community mental health settings was not addressed in either review.

This chapter presents two systematic reviews of the literature regarding the TR, specifically for those treated for psychotic disorders in community mental health settings. This chapter has two main sections:

- A systematic review of literature linking ratings of TRs with clinical and functioning outcomes (SR1).
- A systematic review of the associations between TRs and various predictor variables including demographic and functioning variables (SR2).

3.1. Systematic Review 1 – Therapeutic Relationships as a predictor of outcome

3.1.1. Method

3.1.1.1. Study selection criteria

All types of study designs (excluding case studies and qualitative studies) linking TRs to outcomes for individuals with psychotic disorders were included in this review.

3.1.1.2. Measurement

Studies using non-standardised measures of TRs were excluded. Using the same methodology as the two meta-analyses in this area,^{96;99} all quantifiable measures of outcomes measured *subsequently* to TR were included; that is, purely cross sectional studies were excluded. No exclusions were made regarding the rater of the TR or outcome.

3.1.1.3. Study participants

Study participants were adults (over 16 years of age) with a psychotic disorder including Bipolar Disorder (however, studies examining Bipolar Disorder exclusively were not included) in some form of case management. Studies with mixed diagnostic profiles were included if at least 60% of the sample had a psychotic diagnosis and the remaining sample had a serious mental illness (axis 1). No exclusions were made according to medication use or comorbid diagnoses.

3.1.1.4. Interventions/treatment

With the exception of interventions without one-to-one interactions (e.g., group therapies) and therapy based studies, no exclusions were made according to interventions or treatment type. No exclusions were made regarding length of treatment.

3.1.1.5. Search methods

A computer based search of electronic databases listed in Table 3.1 was conducted. The following search terms were used:

1. therapeutic alliance, working alliance, helping alliance, therapeutic bond, alliance, Therapeutic Relationship, professional-patient relationships and doctor-patient relationship
2. psychosis, psychotic, bipolar disorder, schizophrenia

Results from each group were combined using an 'OR' command and then group 1 and 2 were combined using an 'AND' command. A search was made for grey literature on the internet using MedNet, OMNI, dogpile and Google Scholar.

Table 3-1: Databases and dates searched for SR1

Database	Dates covered
British Nursing Index and Archive	1985 – May 2012
EMBASE Classic and EMBASE	1947 – May 2012
Health Management Information Consortium	May 2012
Ovid Medline	1950 to May 2012
PsycINFO	1806 to May 2012
Social Policy and Practice Database Guide	1890 to May 2012

Reference lists of both review articles and included studies were examined for unidentified studies. A hand search of journals where included papers were published was also conducted. Published papers of dissertations and conference presentations were sought. If none were found, three contact attempts were made to contact the authors of unpublished work/conference presentations. This search originally conducted in October 2010, was updated in May 2012.

3.1.1.6. Quality assessment

Using the STROBE statement¹⁰⁰ as a guide, studies were reviewed to assess quality, and poor quality studies were excluded.

3.1.1.7. Data extraction

The following data were extracted: publication year; study design; country of data collection; sample size; sample % male; sample % psychosis; treatment setting; type of treatment clinician; measure of TR; rater of TR; timeframe of rating of TR; outcome measures; outcome raters; timeframe of outcome ratings; and results.

3.1.1.8. Co-rater

Once duplicate studies were removed from the electronic search, a co-rater examined all records to assess for inclusion. There was initial agreement on

92% of studies. All discrepancies were discussed and final agreement was reached on all records.

3.1.2. Results

3.1.2.1. *Included studies*

The study selection process is outlined in Figure 3-1: Selection of studies. The initial search yielded 1988 records. Removal of duplicates returned 1527 records. Titles and abstracts were scanned for inclusion, leaving 202 records which were printed and examined in detail. 13 studies were finally included; their methodology is summarised in Table 3-2. (NB: the Catty studies are counted as one in the total, but their methodologies are tabulated separately).

Some well-known studies that are often cited in literature reviews in this area were excluded from this review as they did not meet the entry criteria. For example, Frank and Gunderson's 1990 study⁹⁴ was excluded as it is a psychotherapy based study.

3.1.2.2. *Quality of included papers*

The main methodological issues common to all studies were a lack of description or consideration of selection and attrition biases leading to questions about generalisability of the findings. Other methodological issues were: small sample sizes; a lack of control or comparison groups; and a lack of controlling for baseline measures in longitudinal analysis.

3.1.2.3. *Measures of TR*

The Working Alliance Inventory (WAI)⁹⁷ (both the short and long versions) was the most frequently used measure of TR. Other measures included: the Helping Alliance Scale (HAS),¹⁰¹ and the Active Engagement Scale (AES).⁹⁴

3.1.2.4. Settings and methods

The setting was not clearly described for two studies^{102;103} but the remaining studies were set in community mental health teams and case management relationships. The outcome timeframe ranged from 3 to 24 months. All studies were non-experimental, observational with no controls.

Figure 3-1: Selection of studies for SR1

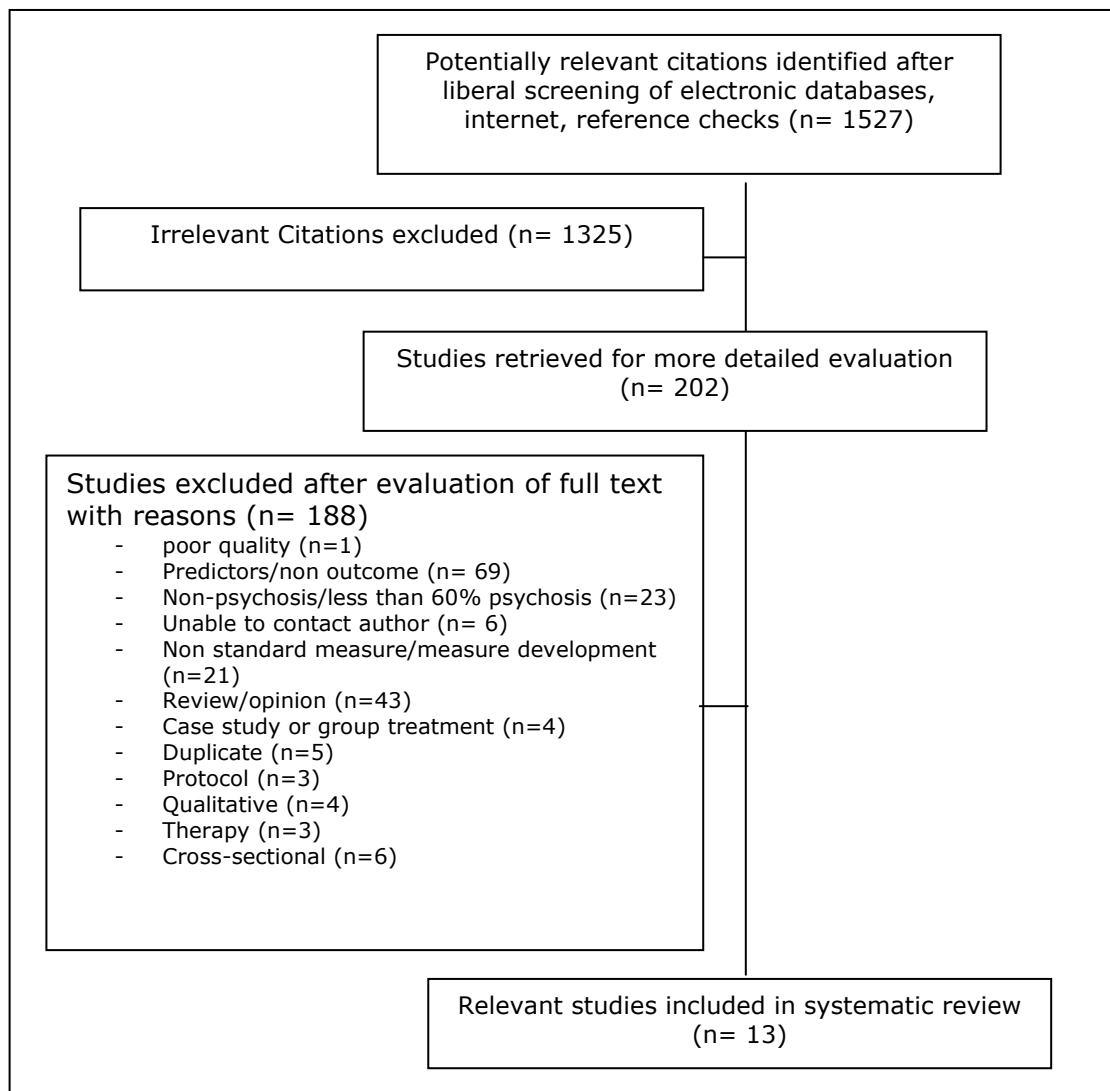


Table 3-2: Methodology of studies

Paper	Predictors of employment for people with severe mental illness	TR: specificity in predicting outcomes for people with psychosis using clinical and vocational services	Client outcomes and the working alliance in assertive community treatment programs	Case management relationship and outcomes of homeless persons with SMI	Psychiatric hospitalisations, arrests, emergency room visits ... findings from a RCT of 2 ACT programs	Client outcomes and the working alliance in the client-CC relationship: a causal analysis
First author	Catty ¹⁰⁴	Catty ¹⁰⁵	Calsyn ¹⁰⁶	Chinman ¹⁰⁷	Clarke ¹⁰⁸	Cunningham ¹⁰⁹
Pub year	2008	2010	2004	2000	2000	2007
Summary of method	RCT of supported employment - specialist vocational services. Used alliance ratings to predict work status at 6 months.	RCT of supported employment - specialist vocational services. Examined clinical and social functioning at 6 months.	Observational - no control. SU seen at baseline, and 3, 15 and 18 months. 3 and 15 month alliance ratings used to predict 18 month outcomes	Observational - no control. SU-rated alliance at baseline, 3 and 12 months used to predict (homelessness, symptoms, social functioning and satisfaction) outcome at 12 months	Observational - secondary use of data from RCT (ACT consumers, ACT non consumer, usual care). CC baseline ratings of WAI used to predict (hospitalisation, emergency room visits, homeless and arrest) outcomes at 24 months.	Secondary analysis (Calsyn) trial compared with assertive community treatment, integrated assertive treatment
Country	International	International	USA	USA	USA	USA
Sample size	312	312	98/126	3481	130/163	162
Sample % male	60	60	76%	64%	61%	74%
Sample % psychosis	100	100	91%	81%	100%	86%
Treatment setting	CMH- intensive vocational support	CMH intensive vocational support	Assertive community mental health for Homeless SU with SMI and substance abuse diagnoses	Outreach and ICM to homeless with SMI	Assertive community mental health for SMI	Assertive community mental health for SMI
Clinician	VW and clinician	VW and clinician	CC	CC	CC/Consumer CC	CC
Measures of TR	HAS	HAS	WAI -10 items	WAI	WAI - 36 item	WAI -10 items
Rater of TR	SU, VW	SU, VW	SU and CC	SU	CC	SU
Timeframe of TR	baseline, 6,12 and 18 months	baseline, 6,12 and 18 months	3 and 15 months	3 months.	baseline	3 and 15 months
Outcome measures	job - yes/no; number of days employed; number of hours employed	PANSS, GAF, depression and anxiety, social disability, QOL, Needs	1. days stable housing (SU) 2. income (SU); 3. psychiatric distress (SU); 4. BPRS (R); 5. days alcohol/drug use (SU); 6. severity of substance use®	1. social support; 2 homelessness; 3 Depression; 4 client rated psychosis; 5 quality of life; 6 addiction severity; 7 substance abuse	1. hospital use; 2. incarceration, 3. emergency room visits and 4. homelessness	1. BPRS (R); 2. Substance abuse (SU)
Outcome raters	R	R	SU and R	SU and R	SU	SU and R
Outcome timeframe	6,12 and 18 months	6,12 and 18 months	18 months	12 months	24 months	baseline, 9 and 8 months

Abbreviations: SU: Service user; CC: care coordinator; VW: vocational worker; CMH: Community Mental Health; HAS: Helping Alliance Scale; WAI: Working Alliance Inventory; QOL: Quality of Life; GAF: Global Assessment of Functioning; PANSS: Psychopathology Scale measuring positive and negative symptoms; R: Researcher; SMI: severe mental illness; USA: United States of America; RCT: randomised controlled trial; BPRS: Brief Psychiatric Rating Scale; ICM: intensive case management; ACT: assertive community treatment.

Table 3-2 (Continued)

Paper	How the TR in the treatment of patients admitted to assertive outreach affects rehospitalisation	The relationship between alliance and rehabilitation outcomes in schizophrenia	Process and outcome in a hostel outreach program for homeless clients with SMI	Subjective illness theory and antipsychotic medication compliance by patients with schizophrenia	Predicting medication non-compliance after hospital discharge among patients with schizophrenia	Assessing clinical predictions of early rehospitalisation in schizophrenia	The role of helping alliance in psychiatric community care: a prospective study	Predictors of risk of non-adherence in outpatients with schizophrenia and other psychotic disorders
First author	Fakhoury ¹¹⁰	Gehrs ¹¹¹	Goering ¹¹²	Holzinger ¹¹³	Olfson ¹⁰³	Olfson ¹⁰²	Priebe ¹⁰¹	Weiss ¹¹⁴
Pub Year	2007	1994	1997	2002	2000	1999	1993	2002
Summary of method	Prospective, observational study of 'established' and new patients. Alliance at baseline predict rehospitalisation over 9 months	Prospective design: newly established rehab dyads rated alliance at baseline and three months later.	Prospective: entrants to hostel outreach program observed over 18 months. 9 month alliance to predict social function	Patients discharged from hospital prospectively observed over 3 months	Prospective study following inpatients from discharge to 3 months to assess medication compliance	Prospective study following inpatients from discharge to 3 months to assess rehospitalisation	Prospective observational study over 20 months. Alliance at baseline to predict rehospitalisation at 20 months	Prospective longitudinal analysis
Country	UK	Canada	Canada	Germany	USA	USA	Germany	USA
Sample size	446/482	22	55	60/77	213/316	262/316	72/100	162
Sample % male	64.50%	72	58	60	60	61	48	63
Sample % psychosis	73% Schizophrenia	100	86	100	100	100	83	100
Treatment setting	Assertive community mental health for SMI	Rehabilitation program	Hostel outreach program; assertive case management for homeless SMI	Discharged from hospital	[unknown]	[unknown]	COMMUNITY MENTAL HEALTH	Day hospital/outpatient clinic
Clinician	CC	Rehabilitation therapist	CC	Psychiatrist	[unknown]	[unknown]	CC	Treating clinician
Measures of TR	HAS	WAI – 36 item	WAI – 36 items	HAS	AES – 6 item	AES – 6 item	HAS	WAI
Rater of TR	CC	SU and clinician	SU and clinician	SU	Inpatient clinician	inpatient clinician	SU	Treating clinician
Timeframe	Baseline	baseline	9 and 18 months	Baseline-	discharge from hospital	discharge from hospital	Baseline	Baseline
Outcome measures	rehospitalisation	1. MGAS 2. Problem list	1. BPRS - R; 2. SLOF - functioning - R	compliance	medication compliance	rehospitalisation	rehospitalisation, housing, work	medication non-adherence
Outcome raters	[unknown]	SU and clinician	R	R	R	R	R	Treating clinician
Outcome timeframe	9 months	3 months	18 months	Discharge and 3 months	3 months	3 months	20 months	survival to non-adherence

Abbreviations: AES: Active Engagement Scale; SU: Service user; VW: vocational worker; CMH: Community Mental Health; HAS: Helping Alliance Scale; WAI: Working Alliance Inventory; QOL: Quality of Life; GAF: Global Assessment of Functioning; PANSS: Psychopathology Scale measuring positive and negative symptoms; R; Researcher; UK: United Kingdom; USA: United States of America; BPRS: Brief Psychiatric Rating Scale; SLOF: Social Functioning; MGAS: Functioning; CC: Care coordinator.

3.1.2.5. Are ratings of Therapeutic Relationships related to outcome?

Due to the heterogeneity of both measures and raters of TRs and the outcomes measured, it was decided that a meta-analysis would not be appropriate. Outcomes investigated by the studies included symptoms, functioning, housing, hospitalisation, medication and treatment adherence. Each will be discussed individually and are summarised in Appendix A. For convenience, each study will be referred to by the first author only (e.g., Catty 2008¹⁰⁴).

Hospitalisation

Four studies examined the relationship between TRs and subsequent hospitalisation. Three of the studies used clinician ratings of the TR. Clarke¹⁰⁸ examined time to rehospitalisation over two years in 130 individuals with psychotic disorders from assertive outreach teams in the USA. CC ratings on the WAI at baseline were not able to predict rehospitalisation. Likewise, Olfson 1999¹⁰² followed 262 inpatients from discharge to three months to assess rehospitalisation. Ratings from inpatient clinicians on the AES were not predictive of rehospitalisation. In a study of 'established' (in care for greater than three months) and new patients (in care for less than 3 months), Fakhoury¹¹⁰ tested whether CC ratings on the HAS predicted rehospitalisation over 9 months in assertive outreach teams in London. In this study, CC ratings on HAS significantly predicted rehospitalisation for new but not established patients.

The only study to use SU ratings on TRs was a study of 72 community patients in Berlin over 20 months conducted by Priebe.¹⁰¹ Using single items of the HAS, SU views on the 'adequacy of treatment' had a small association to partial hospitalisation (day hospitals) and 'feeling better after a session' had a small association with partial and full hospitalisation. Calculating a Hospital Index (HI = number of full and partial hospitalisation divided by overall days hospitalised), the authors found no significant associations with ratings of CC 'understanding', 'criticism' and 'involvement'. However the following comparisons with the HI were significant: SU views on whether they were receiving the right treatment and feeling better after a session.

In summary, two of the four studies found no association between ratings of TRs and hospitalisation. The significant associations found in the other studies related to either SU ratings (although this was on single items of a scale) or CC ratings for newly hospitalised SUs.

Housing

Four studies examined the association between TRs and housing. Two studies examined the association for homeless individuals with serious mental illness (SMI) treated in specialised assertive outreach programs. Firstly, Calsyn¹⁰⁶ followed 98 SUs over an 18 month period. Controlling for baseline rates, they found that days in stable housing at 18 months were significantly associated with a) SU ratings on WAI at three months, but not at 15 months, and b) CC ratings on WAI at 15 months, but not at three months. Secondly, in a large study following 2798 homeless SUs with SMI for 12 months, Chinman¹⁰⁷ found three month SU ratings on WAI were associated with days spent homeless over 12 months, but there was no effect for baseline ratings. Priebe¹⁰¹ found SU ratings at baseline were not related to a housing index (which monitored five levels from hospitalisation to independent living) over 20 months. These findings suggest that once established, early SU ratings may be predictive of housing outcomes. Clarke¹⁰⁸ also examined housing and found CC ratings on WAI predicted time to homelessness over 24 months.

In summary, five of nine tests reported indicate a significant association between ratings of TRs and housing outcomes.

Medication adherence

Three studies examined the association between TRs and medication adherence. Holzinger¹¹³ followed 60 individuals with psychotic disorders for three months in Germany. SU ratings on HAS were taken at discharge and were rated with respect to the prescribing hospital psychiatrist. Several predictors of compliance at three months were entered into a regression equation. The overall model predicted 20% of variance, HAS scores and 'attitudes towards psychotropic drugs' were significant predictors.

The other two studies examined CC ratings. In a prospective study following 213 inpatients from discharge to three months to assess medication compliance, Olfson 1999¹⁰² found inpatient clinician ratings at discharge distinguished medication compliance and non-compliance at three months. Weiss¹¹⁴ examined CC ratings on WAI at baseline and medication adherence over an average of seven months. Ratings on WAI significantly contributed to the regression model predicting adherence.

In summary, all three studies found significant associations between TRs and medication adherence, regardless of outcome timeframe (which ranged from 3 to 20 months) and rater.

Functioning

Five studies examined functioning. Examining global and social functioning, three studies^{105;107;112} found no association with SU ratings. However, Catty 2010¹⁰⁵ found that vocational workers' (VW) views on the TR at baseline predicted both global and social functioning.

Two studies examined the relationship between TRs and vocational outcomes. Priebe¹⁰¹ found change in levels of occupational obtainment (measured on a work axis of four points from inability to work to full time job) at 20 months were correlated with SU ratings of CC's understanding and criticism. Catty 2008¹⁰⁴ found SU ratings regarding their relationship with a VW were significantly associated with the binary outcome of employment obtainment and number of hours in paid employment.

In summary, SU ratings were not predictive of social and global functioning, however there is some evidence to suggest a link with clinician ratings. Conversely there was rather consistent evidence for an association between TRs and vocational functioning, although this was only investigated by two studies.

Symptoms

Five studies examined the association between TRs and psychopathology. SU ratings were found to predict psychopathology in two studies using similar samples comprising Assertive Outreach SUs,^{106;109} but not in the remaining three studies (one vocational and two homeless samples).^{105;107;112} In Calsyn¹⁰⁶ and Catty 2010¹⁰⁵ studies there was some limited evidence for an association between CCs' or VWs' ratings on TRs and subsequent psychopathology.

In terms of substance abuse, Calysn¹⁰⁶ found no association between SU or CC ratings at either three or 15 months. Similarly, Chinman and colleagues¹⁰⁷ found no differences on substance abuse between three levels of TR.

In summary, only seven of the 25 tests indicate a significant association between TRs and symptom outcomes. There is a suggestion of a small relationship between early SU ratings (three months) and later symptom outcomes (in particular the BPRS) – but is not sustained in later SU ratings. Early CC/VW ratings were not related to symptoms scores, but later ratings (15 months and 2 years) did show a small association to symptom scores at later but more proximal time points. Over half of the studies found no association, and all associations that were reported were small (i.e., $r = -.16$ to $r = -.20$).

Quality of life

Two studies examined Quality of Life (QOL). Catty 2010¹⁰⁵ used Lancashire QOL scale and found a significant relationship between SU-rated TR with their keyworker but not their VW. Likewise, VW ratings were not predictive of quality of life. Chinman¹⁰⁷ found an association with SU ratings and life satisfaction at 12 months.

3.1.3. Summary of Therapeutic Relationships as predictor of outcome

A systematic examination of the literature regarding the relationship between TRs and outcomes for individuals with psychotic disorders yielded

13 studies. Outcomes examined included hospitalisations, vocational and overall functioning, psychopathology and housing. Due to the heterogeneity in outcomes, timeframes, measures and raters, a meta-analysis was not feasible. Overall, however, this analysis suggests there is as much evidence to suggest a lack of association as there is to support a true association between TRs and outcomes. The studies with significant findings found mostly small associations (e.g., Pearson correlations around 0.30), which is generally smaller associations than research in psychotherapy settings.^{96;99} The strongest evidence to support a link between the TR and outcome appears to be related to medication adherence. The poorest evidence is for an association between TR and symptom change. This is consistent with a recently published review¹¹⁵ which concluded that despite the equivocal findings, it is safe to assume a small to moderate association between TRs and outcomes.

Further discussion of these findings is presented in 'Overall consideration of research' (Section 3.3).

3.2. Systematic Review 2: associations of Therapeutic Relationships

3.2.1. Introduction

The aim of this second systematic review was to examine the statistical associations of independent variables with the TR (SR2).

3.2.2. Method

The same method (i.e., search terms) was used as SR1 (see Section 3.1.1) however, in this review, studies with the TR as the dependent variable in longitudinal analyses and/or cross sectional studies were selected. Databases (see Table 3-3) were originally searched in May 2011 and again in May 2012.

Table 3-3: Databases and dates searched for SR2

Database	Dates covered
British Nursing Index and Archive	1985 – May 2012
EMBASE Classic and EMBASE	1947 – May 2012
Health Management Information Consortium	1979 – May 2012
Ovid Medline	1948 - May 2012
PsycINFO	1806 - May 2012
Social Policy and Practice Database Guide	1890 - May 2012

3.2.2.1. Co-rater

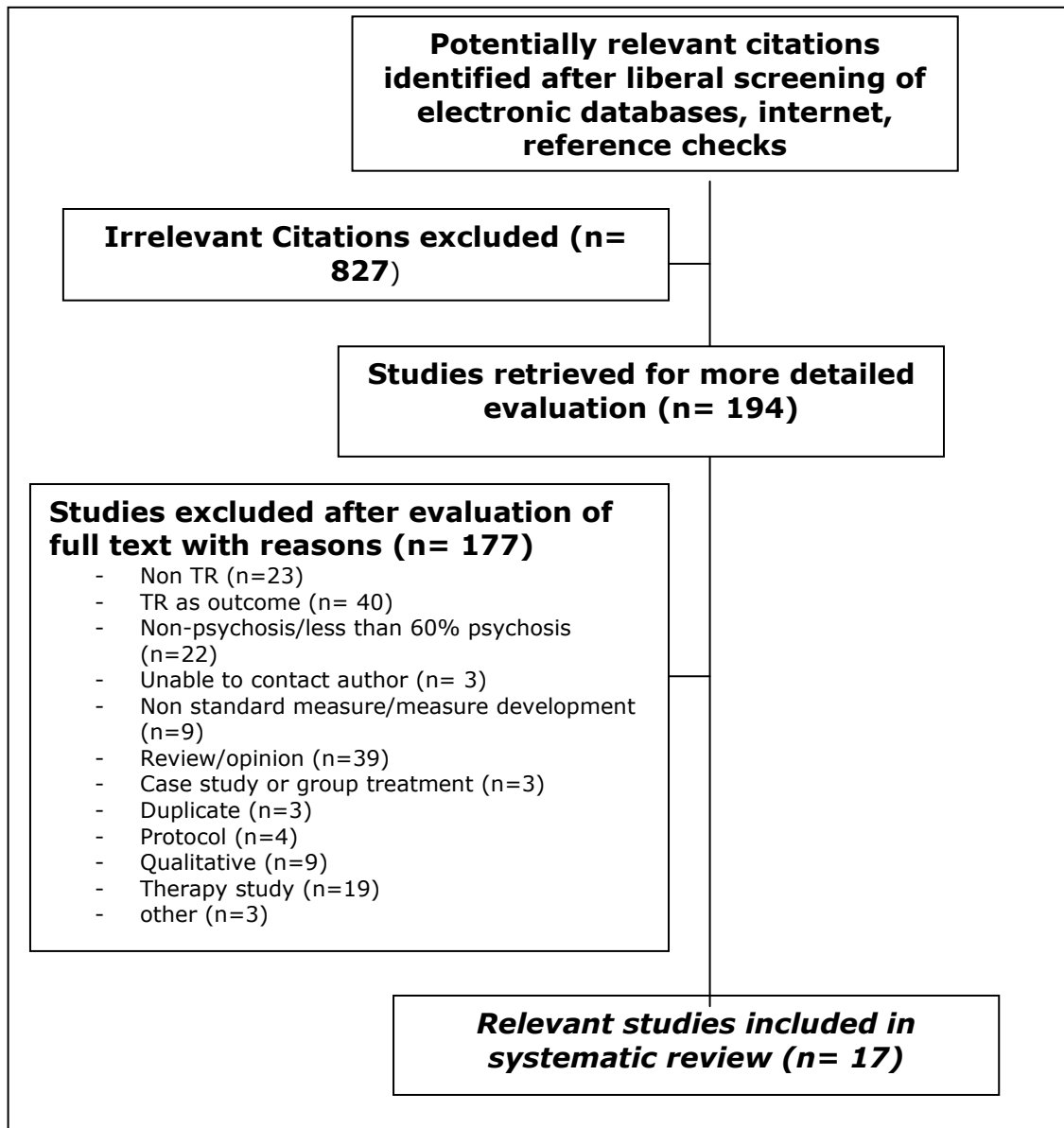
As for SR1, a co-rater examined all records to assess for inclusion. There was agreement on 86% of papers. All discrepancies were discussed and final agreement was found on all records.

3.2.3. Results

3.2.3.1. Included studies

The initial search of electronic resources used the search terms described in Section 3.1.1.5 and yielded 1368 records. An automatic search to remove duplicates returned 1021 records. Titles and abstracts were then scanned for inclusion according to eligibility criteria, leaving 194 records which were printed and examined in detail. Reason for exclusion of papers and summary of selection is shown in Figure 3-2. A total of 17 studies were finally included.

Figure 3-2: Study selection for SR2



NB: figures include original and updated search

Some well-known studies that are often cited in literature reviews in this area were excluded from this review as they did not meet the entry criteria. For example, studies by Draine and Soloman^{116;117} did not report the percentage of participants with a psychotic disorder and included participants with Axis II disorders.

3.2.3.2. *Quality of included papers*

No studies were deemed of insufficient quality to include in the review. Issues common to all studies were the same as for SR1 i.e., a lack of

description or consideration of selection biases and attrition biases; small sample sizes; a lack of control or comparison groups typical in cohort designs; and a lack of controlling for baseline measures in longitudinal analysis.

3.2.3.3. Measures of Therapeutic Relationships

The WAI⁹⁷ was the most frequently used measure of TR and used in six studies. Other measures included: the HAS,¹⁰¹ the Working Relationships Scale (WRS)¹¹⁸ and the Questionnaire on Therapeutic Alliance (QTA).¹¹⁹

3.2.3.4. Settings and methods

Most of the studies were set in the community. Three studies were set in inpatient settings. Four studies were longitudinal and the remaining were cross sectional. All were observational or secondary analyses of randomised controlled trial data. Study methodologies are summarised in Table 3-4.

3.2.3.5. Predictors of Therapeutic Relationships

Due to the heterogeneity of both measures and raters of TR and the outcomes measured, a meta-analysis was not appropriate. Predictors of TRs included demographics, symptoms, functioning, hospitalisation, medication and treatment adherence. Each will be discussed individually and are summarised in Appendix B through to Appendix F. As for SR1, only the first author will be used to denote the study.

Demographics

The association between the TR and a variety of demographic variables was investigated (Appendix B). Demographics included age, education, ethnicity, gender, living status, immigrant status, and gender match. The vast majority of investigations (27/31) found no association. The exceptions were as follows: McCabe 2003¹²⁰ found a positive association (sustained in multivariate analyses) with age and SU-rated TRs in their first admitted sample, but not the long-term admitted nor the discharged

sample; Catty's¹²¹ secondary analysis of a trial of vocational interventions found an association between immigrant status and SU-rated TRs, but this was not maintained in multivariate analyses and between clinician-rated TRs and gender match with the SU, which was maintained in multivariate analyses; Hamman's¹²² investigation of preferences for shared decision making (SDM) found that doctor's rated female SUs as developing stronger TRs than males. Duration of illness¹²² and age at onset¹²¹ were also not associated with TR ratings.

In summary, there was very little evidence to suggest an association between demographic variables and ratings of TRs from either a clinician or SU perspective.

Service delivery, use and adherence

Service delivery, use, and adherence associations with TRs are shown in Appendix C. Variables included the length of relationship between SU and clinician, type of intervention, participation in decision making and/or experience of coercion and percentage of SU needs that were met.

In terms of participation in decision making, a fairly consistent finding emerged: increased participation was associated with stronger TRs¹²² whereas the use of coercion¹²³ or leverage tactics¹²⁴ were linked with poorer TRs. Additionally, difficulty in communication¹²⁵ was associated with clinician-rated TR.

Table 3-4: Methodology of studies SR2

	Payeeship, Financial leverage and Client-provider relationship	Predictors of therapeutic alliance in early psychosis	Attachment theory: a framework for understanding symptoms and interpersonal relationships in psychosis	Predictors of Working Alliance in Assertive Community Treatment	TR in vocational rehabilitation: predicting good relationships for people with psychosis
First author	Angel ¹²⁴	Bourdeau ¹²⁶	Berry ¹²⁷	Calsyn ¹²⁸	Catty ¹²¹
Pub Year	2007	2009	2008	2006	2011
Type	Observational	Observational study	Observational study	sub study of RCT	Secondary analysis of RCT data
Cross/Longitudinal	Cross sectional	Cross sectional	Cross sectional	Longitudinal	Longitudinal
Summary of method	Cross sectional study of adults in community case management and links between financial management, leverage and relationships.	Recruited from early psychosis settings, cross sectional.	(Presume) cross sectional analysis of attachment styles in psychosis and their relationship to WAI in sample of 96 individuals with psychosis	Secondary analysis of RCT comparing assertive community treatment, integrated substance misuse treatment and treatment as usual. Using only first two groups.	Secondary analysis of RCT trial of standard versus specialised vocational services. Vocational worker and SU-rated alliance and other variables at baseline, 6, 12 and 18 months.
Country	USA	Canada	UK	USA	6 European centres
Sample size	205	150	96	115	312
Sample % male	57	61	68%	75%	60%
Sample % psychosis	66%	100	100%	100%	100%
Treatment setting	Case management	Early psychosis	Case management	Case management	vocational services in community
Clinician	CC	CC	CC	CC	VW and Keyworker
Measures of TR	Working Relationship Scale (WRS)	WAI - 36 item	WAI - 12 items	WAI - 10 items	HAS
Rater of TR	SU	SU	SU and clinician	SU and clinician	SU, vocational worker
Timeframe	cross sectional	< 2 years in treatment	<i>Unknown</i>	3 and 15 months post entry to treatment	baseline, 6, 12, 18 months
Predictors	1. Payee status of CC; 2. Leverage;	1. Symptoms; 2. Insight (Insight scale); 3. Friendship, quality of life, side effects	Attachment style	3 months: SU characteristics: race, gender, age, schizophrenia diagnosis, willingness to seek help; baseline BPRS, baseline income, baseline readiness to change, baseline conflictual relationship. Treatment variables: transportation, counselling about feelings, ADL, program contacts	Vocational intervention model; SU age, gender and diagnosis, living situation, immigrant status, education, age at first contact with MHS, number of admissions, functioning, anxiety, depression, symptoms, social disability, QOL, needs, self-esteem, sex of vocational worker, length of relationship and change in clinical symptoms and social functioning.
Predictors raters	SU; Researchers	Researchers; SU self report	SU	objective; SU self-report	Researcher
Timeframe	Cross sectional	cross sectional	?	3 and 15 months	Longitudinal

Abbreviations: TR: Therapeutic Relationship; ADL: Activities of Daily Living; HAS: Helping Alliance Scale; KW: Keyworker; Mental Health Services: MHS; QOL: Quality of Life; SU: Service User; VW: Vocational Worker; WAI: Working Alliance Inventory; CC: care coordinator; USA: United States of America; CC: United Kingdom; RCT: randomised controlled trial; BPRS: Brief Psychiatric Rating Scale; QOL: quality of life.

Table 3-4 (Continued)

Paper	Interactive risk factors for treatment adherence in a chronic psychotic disorders population	Patient Participation in antipsychotic drug choice decisions	Predictors of treatment non-adherence and engagement in early psychosis	TR and quality of life: association of two subjective constructs in schizophrenic patients	Are TRs in psychiatry explained by patients' symptoms? Factors influencing patient ratings	Therapeutic alliance and outcome in a VA intensive case management program
First author	Corriss ¹²⁹	Hamann ¹²²	Lecomte ¹³⁰	McCabe ¹³¹	McCabe ¹²⁰	Neale ¹³²
Pub Year	1999	2010	2008	1999	2003	1995
Cross/Longitudinal	Cross sectional	Cross sectional	Cross sectional	Cross sectional	Cross sectional	Cross sectional
Summary of method	Observational - patients recently admitted to day treatment program. Review medical records and therapist ratings at 2 weeks post entry.	Examined preferences for involvement in decision making and relationship to TR.	Analysis of early psychosis patients' adherence to treatment and medication.	Analysis of two samples - first admission and long-term sample; followed up at 9 months and 1.5 years respectively.	Analysis of relationship between symptoms and TR for SU with psychosis, alcohol and depressive disorders	Observational study veterans with SMI after 2 years in intensive psychiatric community care program
Country	USA	Germany	Canada	Germany	UK	USA
Sample size	87	300	118	first admission - 90; long-term 168	203 psychosis (excluding other diagnoses)	143/166
Sample % male	64	58	61	first admission - 33; long-term 55	45	96
Sample % psychosis	100	100	100	100	100 (excluding others)	71
Treatment setting	Day treatment	Inpatient	Early psychosis case management	Hospital and post discharge	Admitted then discharged	VA case management
Clinician	Treatment coordinator	Hospital psychiatrist	CC	Keyworker	Primary clinician	CC
Measures of TR	WAI - short form	QTA - 6 items	WAI	HAS	HAS	WAI - 36
Rater of TR	Treatment coordinator	SU and hospital psychiatrist	SU	SU	SU	SU and CC
Timeframe	2 weeks	Two days before discharge	Baseline	Baseline and 9 and 18 months	?	after 2 years in program
Predictors	1. medication adherence; 2. non-medication treatment adherence	Participation preferences; Actual participation; Gender; Age; Duration of illness; Symptoms: BPRS; Education; Insight; Drug Attitudes	medication adherence and engagement	Lancashire Quality of Life;	Symptoms: observer rated (BPRS) and SU self-rated (Von Zerssen Complaints checklist); needs for care (Berlin Needs Assessment Schedule); Age; Sex	1. outcome - SU; 2. outcome - Clinician; 3. community living skills - R; 4. BPRS - R; 5: GAS - R; 6. hospital days
Predictors rater	Treatment coordinator	SU self-report; clinician	Researchers	SU	Observer and SU	SU and CC and researcher
Timeframe	2 weeks	Cross sectional	Baseline	Baseline and 9 and 18 months	Cross sectional	2 years

Abbreviations: BPRS: Brief Psychiatric Rating Scale; GAS: Global Assessment Scale. HAS: Helping Alliance Scale; QTA: Questionnaire on Therapeutic Alliance; SU: Service user; VA: Veteran Affairs; WAI: working alliance inventory; TR: Therapeutic Relationship; CC: care coordinator; USA: United States of America; UK: United Kingdom; SMI: severe mental illness.

Table 3-4 (Continued)

Paper	Traumatic events, posttraumatic stress disorder, attachment style and working alliance in a sample of people with psychosis	Therapeutic alliance, illness awareness, and number of hospitalisations for schizophrenia	Perceived coercion and the TR: a neglected association?	Facilitated Psychiatric Advance Directives: a randomised trial of an intervention to foster advance treatment planning among person with severe mental illness	Establishing mutual understanding in interaction: an analysis of conversational repair in psychiatric consultations	Effective treatment relationships for persons with serious psychiatric disorders: the importance of attachment states of mind
First author	Picken ¹³³	Prince ¹³⁴	Sheehan ¹²³	Swanson ¹³⁵	Themistocleous ¹²⁵	Tyrrell ¹³⁶
Pub Year	2010	2007	2011	2006	2009	1999
Type	Observational	Observational	Observational	RCT	Observational	Observational
Cross/Longitudinal	Cross sectional	Longitudinal	Cross sectional	Longitudinal	Cross sectional	Cross sectional
Summary of method	Sub study of RCT investigating association of trauma and TR.	Examined history of psychiatric admissions and its effect on inpatients' clinicians' ratings of therapeutic alliance.	Examined experience of admissions and perceived coercion and its association with TR in an inpatient cohort.	RCT of F-PADs, comparing those who made an F-PAD with those who didn't on WAI at 1 month.	Conversation analysis of routine clinical consultations. Linking incidences of repair with relationships.	Study of attachment and relationships in case management.
Country	UK	USA	UK	USA	UK	USA
Sample size	110	315	164	469	15 SU; 5 Psychiatrists	54 SU; 21 CCs
Sample % male	90	66%	57%	40%	60%	40% SU; 24% CC
Sample % psychosis	100%	100%	84%	100	100	89%
Treatment setting	Case management	Inpatient	Inpatient	Community mental health	Outpatients	Community mental health
Clinician	CC	Inpatient clinicians	admitting clinician	CC	Psychiatrist	CC
Measures of TR	WAI - 12 item	Psychotherapy status report	HAS	WAI-8 item	HAS	WAI - 36 item
Rater of TR	CC	Inpatient clinicians	SU	SU	SU and Psychiatrist	SU
Timeframe	6 months into trial	3 days of discharge	cross sectional	1 month	Cross sectional	Cross sectional
Predictors	Trauma history and Post Traumatic Stress Disorder	History of hospitalisations	Perceived coercion, negative pressures, procedural justice	Completion of F-PAD	Conversational repairs	Attachment; Self-reported depression; quality of life; Functioning; Hospitalisations; length of relationship; diagnosis
Predictors raters	SU	Researcher, records	SU	Records	Researchers	Researchers/SU/ CC
Timeframe	Cross sectional	Longitudinal	Cross sectional	1 month	Cross sectional	Cross sectional

Abbreviations: TR: Therapeutic Relationship; CC: care coordinator; F-PAD: Facilitated Psychiatric Advance Directives; HAS: Helping Alliance Scale; RCT: randomised controlled trial; SU: Service user; WAI: Working Alliance Inventory; UK: United Kingdom; USA: United States of America.

One study¹²¹ examined the length of relationship, service model and met needs. SU ratings of TRs were associated with the specialist vocational intervention and the proportion of their needs that were met. Interestingly, the length of relationship with the clinician was not associated with SU ratings. Clinician ratings of TRs in this study were associated with length of relationship, with longer relationships associated with poorer TRs. Additionally, stronger TRs as rated by clinicians were associated with a higher proportion of SU's needs being met.

Calsyn¹²⁸ also investigated a range of service use variables including transport, program contacts, help seeking and use of counselling. Their study was a secondary analysis of trial data investigating specialist substance misuse treatment. Both clinician and SU ratings were obtained. SU ratings were positively associated with help seeking and willingness to change, but not with the amount of service contact or types of services accessed. Conversely, clinician ratings were associated with service contacts and the use of transport services.

Two studies^{129;130} investigated the links between TRs and firstly overall treatment adherence and secondly, medication adherence. Both studies were cross sectional and, using the WAI, they found a consistent positive association with treatment adherence. Using CC ratings, Corriss¹²⁹ analysis of 87 patients admitted to a day treatment program found significant positive correlations with each of the subscales of the WAI and treatment adherence. Lecomte¹³⁰ examined the association for early psychosis patients at treatment entry. Using SU ratings they also found a significant association with overall treatment adherence. In terms of medication adherence, there was no association with SU ratings in the Lecomte study, but Corriss found that clinician ratings on two of the three subscales of the WAI were significantly associated with a 4 point likert scale of medication adherence.

In summary, the clearest evidence exists for an association between TRs and participatory models of service delivery and treatment adherence. Additionally, Catty's study provides preliminary evidence for an association

with met needs and TRs. There is also some evidence (e.g., Calsyn) for a differential response of clinicians and SUs, with SU ratings related to the delivery of care and clinicians ratings related to the amount of care provided and through which modalities.

Symptoms

Seven of the 17 studies examined the association between symptoms and TRs (see Appendix D).

Diagnosis

Two studies^{121;128} investigated the association between diagnosis and TRs. Both studies were secondary analyses of trial data, the first examining specialist substance abuse treatment and the second examining specialist vocational intervention. Both studies had 100% psychosis samples and tested both SU and clinician ratings. Neither study found a significant association.

Overall symptoms

Six studies^{120-122;126;128;132} examined the association between overall psychopathology and TRs. Two of these studies used inpatient samples^{120;122} and found moderate univariate associations between SU-rated TRs and overall psychopathology. The remaining studies based in the community found no association between SU ratings and overall psychopathology. One study¹²⁰ used a SU self-report measure of symptoms and found a moderate association in multivariate analyses for an inpatient group, but not a discharged group.

Clinician ratings were used in four^{121;122;128;132} of the six studies, in both inpatient and community samples. Of the four, three studies^{121;122;132} found significant negative associations, suggesting that psychopathology hinders the development of strong TRs for clinicians.

Depression and Anxiety

Four studies^{120;121;126;136} investigated anxiety and depression. Catty¹²¹ found no association between depression and either clinician or SU ratings. However, increases in SU anxiety were associated with stronger clinician-

rated TR. McCabe 2003¹²⁰ used the Anxiety and Depression Subscale of the BPRS in a cross sectional analysis and found univariate associations for first admitted groups and discharged groups, but not hospitalised groups. These associations were not maintained in multivariate analyses. Similarly, Bourdeau¹²⁶ used the BPRS Anxiety and Depression subscale for individuals in early psychosis treatment and found no association. The final study¹³⁶ investigated self-reported depression and found a moderate univariate cross sectional association.

McCabe¹²⁰ also reported analyses of the other sub-scales of the BPRS with rather inconsistent findings, most of which were not sustained in multivariate analyses. Likewise Bourdeau¹²⁶ found that positive and negative symptoms had no association with TRs in their cross sectional study. Two further studies examined other symptom clusters. Calysn¹²⁸ found no association between severity of substance use and TRs as rated by clinicians or SUs. One other study¹³³ investigated trauma experiences and found that neither the clinician knowledge of a SU's trauma history or the SUs symptoms were associated with TRs.

In summary, from the seven studies included in this review there is little evidence for an association between symptoms and TRs. However, there is some evidence for a connection between inpatient status and an association between overall psychopathology and TRs.

Functioning

Three domains of functioning were investigated: global/overall; social; and employment related (see Appendix E).

Global/overall functioning

Three studies^{121;132;136} assessed the association of TRs and ratings on the Global Assessment of Functioning (GAF). Firstly, Catty¹²¹ found a univariate association with clinician ratings at an early stage in treatment, but this was not maintained in multivariate analyses, nor was an association found in the

later stages of the vocational treatment; there was no association between SU ratings and GAF scores in this study. Secondly, Tyrell's¹³⁶ cross sectional study of attachment styles and TRs, found that SU ratings of the TR were moderately associated with GAF ratings. Finally, Neale's¹³² study found that cross sectional CC ratings on WAI were significantly associated with global function at 2 years, but SU ratings were not. Neale also examined community living skills and found an association with CC ratings at 2 years, but not SU ratings.

Social functioning

Six studies examined measures of social function. Clinician ratings of the TR and its association with measures of social functioning were investigated by the Catty¹²¹ and Calsyn¹²⁸ studies. All but one of the comparisons (i.e., social disability in early treatment¹²¹) did not reach statistical significance. In contrast, and with the exception of Catty,¹²¹ SU ratings seem to be consistently associated with measures of social functioning.^{124;126;128;136} Catty examined a temporal association between social functioning and TRs and found no significant association. Conversely, the remaining studies^{124;126;128;136} were cross sectional and found, in the majority of tests (60%), significant associations with TRs. Better social functioning was associated with stronger TRs as rated by SUs and suggests that a general appraisal mechanism may be in operation.

Vocational functioning

In Catty's study¹²¹ of vocational functioning, work history was significantly associated with SU ratings of the TR in the early periods of vocational intervention, but not in the later stages. There was no association with clinician ratings of TRs. This is curious considering the nature of the intervention. Conversely, Calsyn¹²⁸ found that clinician ratings were associated with levels of income, but SU ratings were not. The measures of vocational functioning were quite different, work history versus levels of income, which may partly explain these contradictory findings. Similarly, the Calsyn study was cross sectional, whereas Catty tested the association with historical vocational performance.

In summary, there is rather equivocal evidence for an association with functioning and TRs. On balance, analyses of measures of vocational and global functioning suggest no association with TRs. However, there is evidence for a cross sectional, but not longitudinal, association between social functioning and SU-rated TRs, suggesting current wider functioning with people outside the treatment relationship facilitates stronger TRs, or vice versa.

Hospitalisation

Four studies^{121;132;134;136} examined the association between psychiatric admissions and ratings of TRs (see Appendix F). Neale's¹³² cross sectional study examined rehospitalisation of veterans with SMI (71% psychosis) after two years in intensive case management in Veteran's Affairs (VA) settings in the USA. Neither SU nor CC ratings on the WAI after two years in the service were associated with the number of inpatient days over the two year period. Similarly, Catty¹²¹ found no association with lifetime history of admissions with either SU or clinician ratings at 6 months into vocational treatment. Tyrell¹³⁶ found no association with 12 month history of admissions and SU ratings on TRs.

The only significant association was found in Prince's study¹³⁴ of inpatient clinicians' views on SUs with four or more/less than four lifetime admissions. They found that inpatient clinicians had poorer alliances with those who had more lifetime admissions.

In summary, there is no evidence for an association between SU ratings on TR and history of psychiatric admissions. For clinician ratings, there is a suggestion of an effect, however, like overall symptoms discussed above, this may be limited to inpatient settings where SUs are more acutely unwell.

Quality of Life

Three studies^{121;126;131} examined the association with Quality of Life (QOL) and TRs (see Appendix F). McCabe 1999¹³¹ looked at two cohorts (one first

admission and one longer-term sample) recruited while inpatients and followed up for 9 and 18 months (respectively). McCabe presented cross sectional analysis of SU ratings on the HAS at baseline and 9 or 18 months, and ratings on an indicator of quality of life. In the first admission group, HAS ratings were significantly correlated with 'life as a whole' at baseline, but not 'friends' and not the sum score. There were no significant associations at 9 months. In the longer-term group, all associations were significant. Using the same measures, Catty¹²¹ found no association with either clinician or SU ratings. The final study¹²⁶ used different measures of both quality of life and TRs, and found a moderate association between quality of life and TRs.

These contradictory findings are likely a result of the different measures used and the different samples in each study (i.e., the difference between early psychosis and longer-term service users).

Other associations

See Appendix F for further associations including clinician ratings, attachment, and insight.

Three studies^{121;122;128} looked at the association between clinician ratings and SU ratings and found small to moderate associations. Attachment was investigated in two studies^{127;136} with equivocal findings. Hamman¹²² and Bourdeau¹²⁶ investigated insight. Hamman's inpatient study found an association with clinician-rated TR and insight, but not SU-rated TR. Using the same insight scale, Bourdeau's study of early psychosis treatment service found an association with SU ratings of TR. These findings provide further evidence for a differential effect of inpatient and community based SUs.

3.2.4. Summary of statistical associations of Therapeutic Relationships

A systematic examination of the literature regarding the association between variables and ratings of TRs for individuals with psychotic disorders yielded 17 studies. Predictors included demographic, symptom and functioning variables. The heterogeneity in measures of TRs and predictor

variables, timeframes and raters meant that a meta-analysis was not feasible. Like SR1 presented earlier in this chapter, the effect sizes were generally small to moderate.

Overall, there is limited evidence for a true association with many of the variables and TRs. The strongest evidence appears to be for a link between symptoms and TRs for inpatient samples, and social functioning in cross sectional studies. However, the heterogeneity and small amount of studies investigating each predictor variables prevents making firm conclusions.

3.3. Overall consideration of research

3.3.1. Measurement

There were a number of measures of TRs in these two reviews and it is feasible that they are measuring different constructs. In their meta-analysis, Horvath and Symonds⁹⁶ suggest that different measures had a differential effect, yet the Martin and colleagues⁹⁹ repeat of this review did not support this finding. In a study of the conceptual bases of common measures of alliance, Catty and colleagues⁹⁸ suggest that the measures found in these two reviews define TRs in different ways. The WAI, for example, uses Bordin's Pan theoretical definition of TRs (see Section 2.4.7), whereas the HAS appears to assess a more Rogerian definition of unconditional positive regard and empathy (see Section 2.4.1). These findings suggest that studies using different measures of TRs may be assessing different constructs, which may in turn, provide some explanation for the equivocal nature of the findings in these two reviews.

3.3.2. Raters of Therapeutic Relationships

There was also considerable variation in the raters of TRs. Some studies used only one rater (e.g., either clinician or SU), whereas other studies used a combination of raters of TR. Some authors (e.g.,¹⁰⁵) have proposed that SU ratings of TRs correlate more with subjective measures of outcome, suggesting that their ratings may be more akin to an overall measure of satisfaction. More recently, there has been a suggestion that TRs are among several constructs used as patient-rated outcomes that may

measure a general appraisal tendency.¹³⁷ There is some support for these propositions in this chapter, for example there were few significant associations found between SU ratings of TRs and symptoms in either review, but a rather consistent positive association with quality of life, social functioning and met needs (including vocational) – perhaps indicative of overall satisfaction.

The most consistent link between TRs and outcomes/predictors was in medication/treatment adherence, however, the majority used clinician ratings of TRs and those using SU ratings had equivocal findings.

There are several potential reasons for the differential associations between SU and clinician ratings. Firstly, it is possible that SUs and clinicians may have different expectations or goals for interactions and therefore different understandings of what constitutes a strong TR. This proposition has some support in the literature. For example, an examination of unmet needs in community mental health suggests that reducing SU-rated unmet needs, but not clinician-rated unmet needs, improves TR;¹³⁸ suggesting that goals or expectations may differ. A second explanation is that ratings of TRs are measuring different latent variables such as satisfaction versus engagement. This proposition is further supported by the small to moderate correlations between the two ratings, consistent with a meta analysis in psychotherapy.¹³⁹ Additionally, some literature shows an association between clinician ratings and pro-treatment attitudes and behaviours in SUs (see ¹⁴⁰) and indeed Catty and colleagues⁹⁸ analysis discussed above supports this.

3.3.3. Timeframes

There was variation in timeframes for both measurement of TRs and outcome/predictor variables. Firstly, with respect to the initial or baseline measurement of TRs, some studies assessed the relationship at first meeting or in the preliminary stages of a relationship, with other studies assessed the TR several months into the relationship (e.g., Gehrs¹¹¹ assessed the TR 2-7 months after first meeting versus Neale's study¹³² which assessed the relationship after 2 years). In this context, the examination of these studies as a whole requires comparison of 'established' pairs versus new pairs. Indeed, Chinman and colleagues¹⁰⁷ question the practice of assessing the relationship before any meaningful relationship

could be established and also raise a question regarding assessment after many months as they may be confounded by overall improvement. This latter point reinforces the construct ambiguity discussed above – that is, the relationship rated at later points may be a measure of satisfaction or engagement. Without consistency in the timing of the assessment of the relationship, there remains a lack of comparability in the studies and fundamental questions about what is being measured.

3.3.4. Different treatment settings

Studies from inpatient settings were included in these reviews as hospital care is, for many, a salient component of community mental health care. However, purely inpatient based studies had quite consistently different findings from those based entirely or partially within the community. For example, symptoms were associated with SU-rated in inpatient studies but not, in most cases, in community studies. This suggests that TRs are affected by the treatment setting – a finding that warrants further investigation, in particular if this extends to different treatment models in community settings.

3.4. Chapter summary

Two systematic reviews of the literature linking TRs with outcomes and predictors for individuals with psychosis found limited evidence supporting an association. The lack of clear definition of TRs for community mental health settings outlined in Chapter 2 has clearly influenced much of the research conducted to date. In the next chapter, qualitative literature is reviewed in order to further understand current interpretations of TRs with a view to developing a new model, and to further refine its measurement.

4. Influences on and characteristics of Therapeutic Relationships in community mental health: a Critical Interpretive Synthesis

4.1. Background

As presented in the preceding chapters, there is no overarching model/theory to guide the interaction between clinicians and SUs in community mental health. Whilst it is clear that research has begun to consider TRs in MHS, the evidence base is lacking, in part due to the ambiguity about what is wanted and able to be provided in the treatment of SUs with psychotic disorders in community mental health settings.

This chapter describes the process of conducting a Critical Interpretive Synthesis (CIS) of research to answer the following four questions:

- What are the contextual influences on TRs?
- What do SUs want in their interactions with their clinicians?
- What are those clinicians aiming to provide?
- How is the TR in community mental health best described?

4.2. Methodology

4.2.1. Methods of evidence synthesis

Tools for synthesis of quantitative data, such as meta-analysis are well established¹⁴¹ and most usually perform an aggregative function, that is a summation of findings across a range of studies to generate an understanding of the overall size of effect.¹⁴² Conversely, methodologies designed to synthesise qualitative research are less readily available¹⁴¹ – possibly because of concerns about the validity of synthesising qualitative data and what information such a synthesis should aim to provide.^{141;142}

Qualitative methods of enquiry often aim to explore areas in which there is a lack of clear definition or in depth understanding of a particular phenomenon, for example SUs' opinions about a new intervention. As such, the data emerging from qualitative enquiries tends not to be geared towards developing consensus understandings but is often an exploration of

differences. In such a context, with often quite varied data, aggregative methods of synthesis, such as meta-analysis, would not be appropriate. Noblit and Hare¹⁴³ make the distinction between *integrative* versus *interpretive* syntheses. Integrative reviews, such as meta-analysis, seek to aggregate or pool data and require a basic comparability between the phenomena. Conversely, interpretive reviews seek to explore and understand concepts within the literature. By understanding the contexts within which the data was collected and those in which it was analysed, interpretive reviews develop a theory that explains the inter-relationships between concepts.^{142;144} The main output then, is not a summation of data but rather a theory of the phenomena of interest. As Dixon Woods and colleagues state,

'Interpretive synthesis involves processes similar to primary qualitative research, in which the concern is with generating concepts that have maximum explanatory value. This approach achieves synthesis through incorporating the concepts identified in the primary studies into a more subsuming theoretical structure. This structure may include concepts which were not found in the original studies but which help to characterize the data as a whole.' (p36-37)¹⁴⁴

An interpretive approach has been used in this chapter.

4.2.2. Meta-Ethnography

One of the most commonly used methodologies for interpretive synthesis of qualitative data is Noblit and Hare's meta-ethnography.¹⁴³ It involves three strategies:

- *Reciprocal translational analysis* where key themes in each paper are compared to similar concepts from other papers and a decision is made about the suitability of the original concept in adequately explaining phenomena in the other papers.
- *Refutational synthesis* where themes are identified and areas of disagreement are explored and explained.
- *Lines of argument synthesis* where inferences are made about the phenomena of enquiry, by 'construct[ing] an interpretation of all the studies, their interrelations and context.'¹⁴³

The key aspect of meta-ethnography that distinguishes it from an integrative review is the focus on the *interpretations* of the authors in the original studies, rather than the primary data itself.¹⁴² This differentiation between data has been usefully delineated as first and second order constructs^{143;145} where first order constructs are the understandings of everyday people as exemplified by participants in the studies, and second order constructs are the interpretations of these understandings by social scientists. Through focus on second order constructs, meta-ethnography moved the synthesis from the level of data to the level of interpretation.

Despite its popularity there are some limitations with meta-ethnography. Most importantly, it was developed and designed to synthesise qualitative data only. In areas where there is some conceptual ambiguity however, other forms of data such as quantitative and theoretical data may be useful in developing theory and understandings of a phenomenon. Other criticisms include: limitation in the number of papers included; lack of clarity regarding the independent contributions of the three analytical strategies listed; lack of description of sampling and appraisal of papers; and no clear statement regarding the goal of the synthesis (e.g., theory building) (see ¹⁴¹ for a discussion).

In 2006, Mary Dixon Woods and colleagues¹⁴⁶ published an investigation on access to healthcare for vulnerable groups. They had planned to use meta-ethnography, however, due to the constraints listed above, they needed to modify the concepts and techniques of the methodology to work with the vast numbers of papers relevant to their study. Their modified methodology differed from meta-ethnography on other key components and they coined 'Critical Interpretive Synthesis (CIS)' to describe this new methodology.

4.2.3. Critical Interpretive Synthesis (CIS)

The key points of differentiation between CIS and other methods of synthesis (including meta-ethnography) are the:

- 1) ability to include diverse forms of primary data including qualitative and quantitative data;

- 2) rejection of chronological progression through defined stages, in preference for an iterative and reflective approach to paper selection, critique and analysis;¹⁴⁷
- 3) specified aim to be *critical* through actively examining the way in which the phenomenon is constructed in the literature and the nature of the assumptions on which understandings are based;¹⁴⁷
- 4) explicit acknowledgement of the 'authorial voice'¹⁴⁴ i.e., the potential for a lack of transparency and reproducibility of the analysis, while asserting the validity of the approach through grounding the analysis in evidence, ensuring it is verifiable and plausible.

All four points of difference could be viewed as strengths of CIS.

Incorporating diverse forms of primary data strengthens the validity and applicability of the final analysis. By adopting an iterative and reflective approach, the analyst maximises the chances of a thorough and verifiable interpretation of the literature. A critical approach illuminates contextual and epistemological influences. The acknowledgement of the authorial voice explicitly recognises the requirement for interpretation in synthesising diverse forms of literature. By making this explicit, the reader is invited to weigh the evidence. However, this last point is also the potential criticism of CIS - particularly in contexts such as medical research that emphasise objectivity. To counter this, the analysis must be verifiable and plausible.

The output of a CIS is a '*Synthesising Argument*' defined by Dixon-Woods and colleagues¹⁴⁶ as the integration of:

'... evidence from across the studies in the review into a coherent theoretical framework comprising a network of constructs and the relationships between them. Its function is to provide more insightful, formalised, and generalisable ways of understanding a phenomenon.'
(p5)

A Synthesising Argument may include second order constructs and third order or *synthetic constructs*, the former being the interpretations of primary data from the original authors, and the latter being new constructs generated through analysis of the primary data.

A CIS approach was chosen for this analysis as it was anticipated that diverse forms of literature would be relevant to the questions posed in Section 4.1. Secondly, the 'critical' approach would enable explication of the understanding of the TR in existing research.

4.2.4. Paper selection and inclusion

Selecting papers was an iterative process beginning with reading within and around the subject area of TRs. Key topic searches included communication, power, decision making, needs from interaction, and trust. This process included reference chaining, and searching of grey literature and bibliographic databases. The search continued through the analysis process, particularly when the preliminary analysis suggested new avenues of enquiry.

Typically, examinations of TRs have looked at the views of clinicians who are closest to the SU (e.g., case manager/CC). Increasingly, views of SUs have been considered. However, there have been few examinations of the system within which the relationship operates. Therefore this review purposefully selected papers from authors and subjects from each of the key groups within multi-disciplinary community mental health teams (i.e., SUs, community mental health nurses, psychiatrists and other allied professionals). Papers were selected if they discussed an element of interaction between SUs and clinicians. Papers that did not include a relational component (e.g. SU views on recovery that excluded other actors) were *not* included.

The search included papers from 1990-2011. 1990 was selected as the earliest year for the search strategy as it was the year that Frank and Gunderson⁹⁴ published their much cited paper on TRs for individuals with psychotic disorders and was also the year that the CPA was introduced in the UK. Papers with a particular significance or a unique perspective were short-listed and discussed. Some papers that were initially included (after further reflection) were excluded and different papers covering new areas were purposively sought when new themes arose from the analysis. Thirty-

four papers were originally shortlisted, however some were deemed unsuitable for reasons including: undefined subject sample; mix of diagnostic groups; and a lack of new constructs beyond those in already included papers. Thirteen papers were finally included^{25;148-159} (see Appendix G for a description of settings, authors and reasons for inclusion).

4.2.5. Data extraction and analysis

Each paper was read a number of times. Data or themes from the papers relating to the four research questions were extracted and placed in tables according to first and second order constructs. Commonalities and differences between the second order constructs across the papers were then examined.

Using a critical approach, comparisons were made between papers and gaps and overlaps noted. Third order or 'synthetic' constructs (constructs that encapsulated an issue across a range of papers) were identified, if existing second order constructs didn't adequately capture the data. Each paper was then re-read to identify any missing constructs. A network of second order and synthetic constructs was developed, while regularly checking that the emerging analytical picture adequately reflected the original data. A very simplified example of this process is shown in Table 4-1 and discussed below.

In Table 4-1, rows 1 and 2 presents first and second order constructs from the same paper¹⁴⁸ regarding clinician perspectives on case management. Row 3 is from a paper¹⁴⁹ examining SU responses to compulsory community treatment. The first order construct column contains data from the participants in each study. The second order construct column contains the authors' interpretation of those first order constructs. The third column is the result of the synthesis across both papers.

In row 1, the second order construct reflects a concern regarding passivity of SUs. However, the second order construct in row 2 presents similar passivity as a positive exemplar of compliance. Row 3 presents a SU wanting to stay on a compulsory treatment order as a preventative measure

against possible relapse. When considered together, they are all examples of a form of SU passivity: SUs unwilling or unable to act with self-determination. Such passivity is interpreted in different ways and represents a key construct in the literature: contention around independence. Therefore the third order or synthetic construct that was developed was (in)dependence. There were situations where examples were considered to relate to more than one construct, hence multiple third order constructs in the example below.

Table 4-1: Example of CIS coding process

	First order	Second order	Third order
1	[Client] sees me as her parent... the person who writes out the checks and does her budgeting and decide then (even though the team kind of decides) she's got me as the one who decides whether she gets money or not, extra spending money. So I think she sees me more as the parent role, which is not what I want to be. The minute I get there [to the client's home] that sets up a whole conflict... I try to figure out how do I get myself from that parent role down to just 'I'm just your social worker that you talk with' or whatever	Although done out a sense of concern, setting limits to protect clients from potential harm can introduce a parent-child dynamic into the ICM relationship, according to clinicians.... They felt that this role was externally imposed upon them, in that some of their relationship both made them feel like parents and in turn, made their clients feel like children.	(in)dependence; accountability; ideas of professionalism;
2	when you go work with her, she seems to accept everything you put down for her.	Compliance is a third type of responsiveness that helps case managers gauge feelings of effectiveness with a given client.	goal ambiguity; (in)dependence
3	They wanted to take me off it (compulsory treatment order), but I said I didn't want to. Maybe in a couple of years when I get employment. It's a bit too early to come off it just yet.	in the absence of the supervision, care and support available under the orders, they anticipated the recurrence of their previous difficulties	(in)dependence

4.2.6. Validity checks

The CIS is an interpretative and subjective exercise. One of the ways to enhance the rigour of the analysis is to have someone from outside the phenomena conducting the analysis.^{142;160} As a non-clinician and non-SU, the author has not been socialised into either perspective and therefore can

maintain a level of objectivity. However, to ensure the analysis was valid for these audiences, discussions regarding the emerging constructs were had with clinicians and SUs during the analysis. Additionally, by following some of the steps suggested by Strauss and Corbin¹⁶¹ third order constructs were repeatedly compared to primary data. Finally, all papers were chosen with HL (supervisor) and 5 were co-rated.

4.3. Results

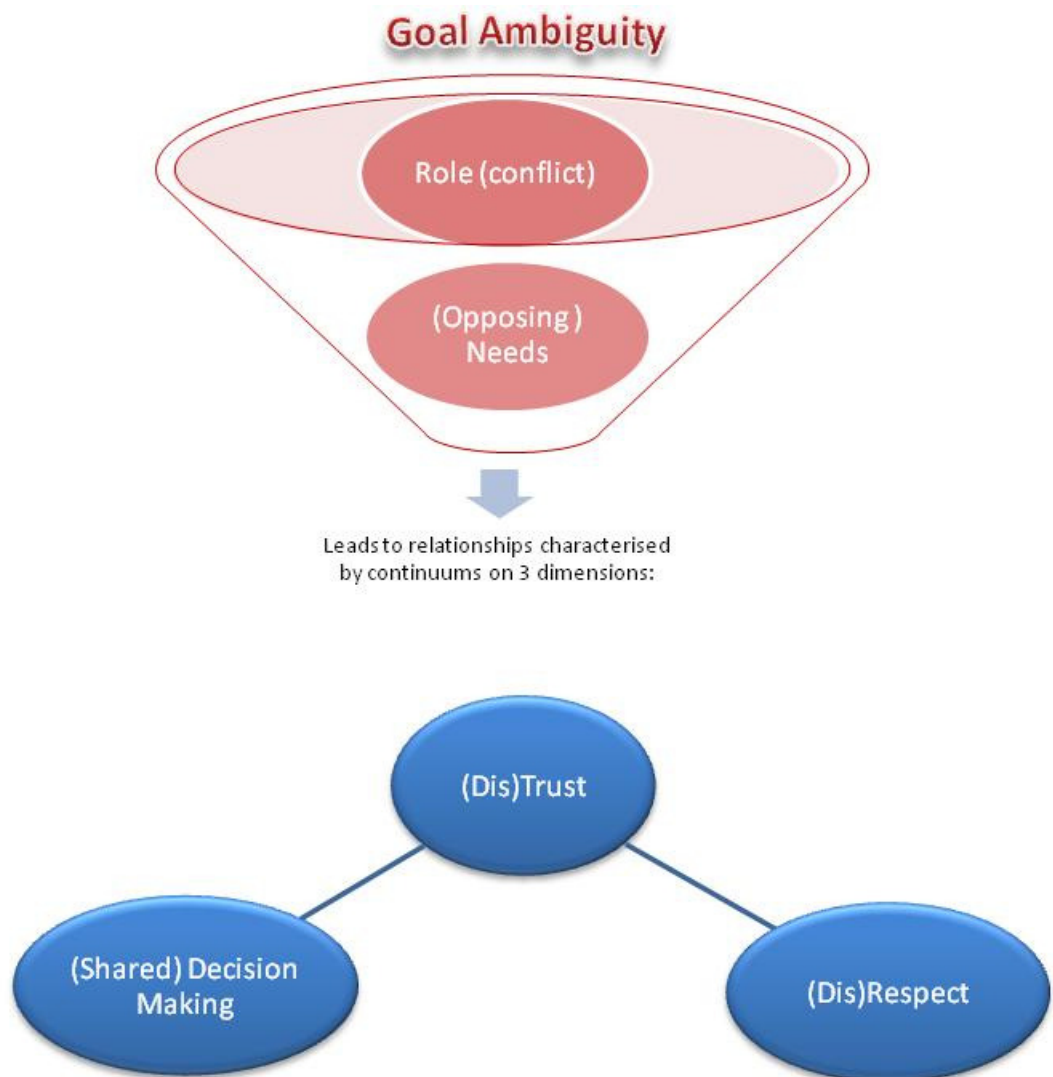
A polarised picture of TRs emerged from the literature. At one end of the spectrum were interactions appraised as mutually beneficial and productive. At the other end of the spectrum were interactions that were largely oppositional and unproductive. These spectrums are characterised by three key third order constructs: (dis)trust; (shared) decision making; and (dis)respect. This polarisation was generated by fundamental ambiguity of purpose or '*Goal Ambiguity*'.

It should be noted that the term 'clinician' is used in this analysis to refer to both psychiatrists and other professional groups such as nurses and CCs. When findings applied to one type of clinician only, it is specified.

4.3.1. Synthesising Argument: Goal Ambiguity

The Synthesising Argument of this CIS was '*Goal Ambiguity*' as shown in Figure 4-1. *Goal Ambiguity* was defined as a lack of consensus about the purpose of interactions between clinicians and SUs in community mental health. Lack of consensus led to ambiguous role definitions, which in turn led to clinicians and SUs interacting with different expectations/needs. The analysis suggests that such goal and role ambiguity ultimately shapes the TR in community mental health treatment settings.

Figure 4-1: CIS Synthesising Argument of Goal Ambiguity



Note: presented to ENMESH conference in 2011

At the centre of *Goal Ambiguity* were two related issues: firstly, whether the goal of the interaction was 'engagement' or 'improvement'; and secondly, the value of the treatment for both SUs and clinicians.

4.3.1.1. Engagement as the goal

'Non-engaged patients are more unwell and socially impaired than those successfully engaged in services' ¹⁵⁴

(Second order, Psychologist, psychiatrists and Social Scientist authors)

*'Client non compliance causes case managers to feel ineffective and powerless, and thereby increases the negative valence of the relationship'*¹⁴⁸

(Second order, allied professionals)

A key question emerging from the analysis was the extent to which interactions between clinicians and SUs were intended or expected to be *therapeutic*, that is working towards improvement. This analysis suggests that rather than 'therapeutic' aims the focus was on SU 'engagement' i.e., medication compliance, participation in and attendance at clinical appointments, and compliance with care plans. In such a model the terms and conditions of interactions are clearly defined: the clinician ensures SUs attend and participate in appointments and continue to take their medication, and SUs are expected to comply.

In principle 'engagement as the goal' is not problematic in and of itself, and indeed it was sometimes linked with constructs of safety – both from clinicians and SUs.¹⁵⁵ However, two problematic and related perspectives emerged from the analysis: firstly, the universality of 'engagement'; and secondly, stagnation at engagement. There was an assumption from clinicians that all SUs should engage with services at all times. Indeed 'disengagement' was presented almost universally as problematic: either the clinician not performing to standard or the SU deteriorating and lacking insight (see ^{155;157} for exceptions). Secondly, it could be argued that once engaged, the focus or goal of treatment should move to functional, psychological or symptom improvement. Yet, with the exception of Kirsch and Tate¹⁵² who discussed 'moving forward', notions of improvement, adjustment or recovery rarely appeared in the literature and if present were often discussed as a means of ensuring engagement. It would be naïve to suggest that clinicians don't hope to help SUs, but the lack of clear constructs regarding the benefit of engagement or moving beyond engagement to improvement was surprising. Similarly, the relative lack of constructs focussed on improvement presents a system to which SUs are

expected to comply, at a potential cost to their own self-determination and independence, for an unspecified benefit.

Interestingly, there were few clear constructs about SU views on the purpose of the interaction. This was possibly a result of the small number of papers found that were written by SUs, however, it was clear that engagement alone was unsatisfactory and that SUs expected interactions to be supportive. For example,

*'The desire to change is nurtured through the relationship, not dictated by one person's plan for another. The outcome is that people don't continue to feel separate, different and alone'*¹⁵⁵
(Second order, SU authors)

4.3.1.2. Value of treatment

*'I just felt I was fobbed off... it was definitely a case with some psychiatrists of 'them and us'. And you couldn't talk on the level at all, so in the end you just didn't say very much... I used to think who it benefits, and thought, not me.'*¹⁵⁷
(First order, SU respondent)

Discourse regarding the value of treatment covered several areas: medication; practical help and punishment. For '*medication*', some papers acknowledged the benefits both from clinicians and SUs, but there were also examples of SU respondents describing the effects of medication as worse than the illness. For example,

*'I prefer it (oral medication) to the depot, 'cos when they used to give me the depot they used to inject me and I couldn't walk properly. My legs were buckling, my hips were... then they took me off the injection. I stopped hearing voices but the side effects were so bad I'd prefer the voices.'*²⁵
(First order, SU respondent)

Such examples question the benefit of seeking and enforcing engagement with treatments that some experience as worse than illness. Although some authors acknowledged that negative side effects may be a reason for

disengagement,¹⁵⁷ the majority of constructs described disengagement as a result of escalation of mental illness. By acknowledging that SUs could disengage due to a perceived lack of benefit, the literature presents SUs as rational actors seeking improvement in their position; yet by attributing disengagement to poor mental health, SUs were presented as lacking capacity to act rationally. This contradiction illustrates the ambiguity of treatment goal.

Another area where the question of the '*value of treatment*' was discussed was '*practical help*'. There was a consensus in the literature that practical help – such as help with shopping, benefits or housing – was a benefit for both SUs and clinicians. For clinicians it was discussed as a good strategy to build trust and engagement, thereby reinforcing the goal of engagement rather than therapeutic aims. For SUs practical assistance, as opposed to medication, was associated with tangible benefit.

One striking construct emerging from the analysis, highlighting the ambiguity of purpose particularly from a SU perspective, was the perception of treatment as a punishment. For example,

*'It was understood that these orders [compulsory treatment orders in the community] were being used as punishments for 'wrongs' committed ...'*¹⁴⁹

(Second order, Social Scientists, psychiatrist authors)

Perceiving clinical intervention as a punishment suggests that some SUs see no value in treatment, but experience it as a negative judgement on their behaviour.

4.3.2. Influence of role conflict

The third order synthetic construct of *Role Conflict* incorporated two sub-constructs: '*Ideas of Professionalism*' and '*Accountability*'.

4.3.2.1. *Ideas of professionalism (boundaries)*

A clear discord in the literature emerged around '*ideas of professionalism*' or what good clinical work entailed in terms of models of interaction. In particular, there was marked variation in views regarding professional boundaries. As outlined in Section 2.4.8, there are marked differences between community mental health delivery and psychotherapy, in particular with reference to boundaries. In this context, the analysis of the literature indicated a lack of clarity about the feasibility and clinical utility of maintaining professional boundaries, and indeed where a boundary should be drawn.

Seven of the 13 papers, presented SUs as wanting clinicians to develop friendships with clinicians, for example, SUs expecting clinicians to share aspects of their personal life and to replace missing social contact in SUs' lives. However, some clinicians viewed such interactions as a neglect or failure in their professional responsibilities. For example,

*'... the clinician members in this study acknowledged that clients sometimes viewed them as friends or friendly companions. Although many felt that while allowing the client this perspective had therapeutic functions (e.g., alleviating loneliness, helping clients feel included), clinicians member themselves avoided thinking of case management relationship as a friendship. Their hesitancy may stem from feeling that relating to clients as 'friends' represents a neglect of their responsibilities as professionals.'*¹⁴⁸

(Second order, allied professional authors).

Conversely, some clinicians wanted to play a number of different roles for SUs, something SUs rejected in preference to maintaining a level of independence from MHS. There was also a suggestion in the literature that the clinicians should be able to engender all roles at different times for the same SU.

The lack of clarity around *boundaries* highlights the *Goal Ambiguity* and the potential for misunderstanding and disagreements between SUs and clinicians regarding which roles should be played by whom and in which contexts. Boundaries intended for therapeutic benefit may actually reinforce the disconnection and social isolation of SUs. Alternatively, a lack

of boundaries may be emotionally taxing on the clinician or endanger an aspect of the SUs' wellbeing.

4.3.2.2. *Accountability*

The second sub-construct of *Role Conflict* was *Accountability*. There was a clear consensus in the literature that clinicians felt, and indeed are held accountable for the behaviour of SUs. For example,

*'Unlike psychotherapists, case managers may perceive that mental health system assigns them full responsibility for the safety and well-being of their clients, which translates into pressure to ensure that clients follow treatment recommendations.'*¹⁴⁸

(Second order, allied professional authors)

As outlined in Section 2.3.4.4, such responsibilities are clearly stipulated in policy. The expectation to ensure SUs follow treatment recommendations is inherent in the construct of *Engagement as the Goal* (see Section 4.3.1.1) and required clinicians to act as monitors and enforcers. Within this discourse, however, there was a suggestion that the 'monitor' role could be problematic. For example, by accepting the position that clinicians are responsible, SUs are excluded from one of the key facets of adulthood – self-determination. For example,

*'Although done out a sense of concern, setting limits to protect clients from potential harm can introduce a parent-child dynamic into the ICM [intensive case management] relationship, according to clinicians.... They felt that this role was externally imposed upon them, in that some of their relationship both made them feel like parents and in turn, made their clients feel like children.'*¹⁴⁸

(Second order, allied professional authors)

However, there were few examples of alternative approaches. Indeed, with the exception of SU authored papers, there was no discussion of clinicians not acting according to the pressure of accountability and allowing SU self-determination.

From a SU perspective, there was disparity regarding the possibility of SUs being accountable for their actions. SU authors Mead and Copeland¹⁵⁵ were unequivocal in the need and capacity for SUs to be held accountable for their own lives, well-being and actions. Yet SU respondents presented different perspectives. For example,

'You get a lot of help. You're supervised in the community, so you don't get worn down and lose control of yourself. They can stop something serious from happening'.¹⁴⁹

(First order, SU respondent).

The two positions are not necessarily exclusive, but perhaps relate to a question of situational capacity, however, the themes of capacity are noticeably lacking from much of the discourse on TRs in the selected papers.

The dilemma of accountability provided a very real tension between the needs of clinicians to fulfil their professional roles and the needs of (at least some) SUs to be treated as self-determining adults.

4.3.3. Opposing needs

'The paradox of ACT is the disparity between outcomes aspired to by a number of interested parties namely participants, carers, clinicians and the community. For Mr B, his desired outcome was to be free from psychiatric services with a job and social network unrelated to mental health. For the clinicians, the emphasis was on reducing admissions and keeping Mr B on atypical, as opposed to typical anti-psychotics. Alternatively Mr B's community might seek more 'normal' social behaviour such as not responding to auditory hallucinations in the street.'¹⁵⁷

(Second order, psychiatrist and social scientist authors)

This analysis suggests that the TRs in community mental health treatment settings are influenced by both the needs of clinicians and SUs, and that these needs may often conflict. Needs emerging from this analysis were often interpersonal needs, rather than clinical. The needs of clinicians

included feeling valued, feeling in control (linked with 'Accountability'), self-protection and interpersonal connection with SUs. Likewise, SU needs included respect, self-determination, self protection, support and security. Many SU and clinician needs were similar but in the relational context may be opposed. For example, in terms of 'feeling valued', clinicians seek recognition for their skills and expertise. For example,

*'There's one [client] I hardly work with at all, but I'm glad I don't, I guess. [...] I've done observed meds [delivering medications and watching the client take them] to fill in for someone... he takes the meds in his hand and turns his back, swallows them, and then more or less dismisses you by walking away... he looks down on us [the team] non-verbally, I think, just in general.'*¹⁴⁸

(First order, clinician respondent).

'Because engaging clients can reportedly be a long and arduous process, sensing that the team and the individual clinicians matter to the client give case managers a benchmark to their progress and helps them to feel rewarded for their efforts. When such feedback is absent however, team members sometimes feel passed over and rejected...'

(related second order from ¹⁴⁸)

The above example shows a first order construct and the related second order construct. It is implied in the first order and reinforced in the second order that the clinician's role (delivering forced medication), even when it is unwanted, warrants positive feedback. The feelings of 'rejection', illustrate both universality of assumptions of clinical beneficence, but also that interactions are an interpersonal process affecting both clinicians and SUs. In this example both the original clinician participant and the authors seem very disconnected from the SU's experience of forced treatment. Here the clinician's need 'to be in control' conflicted with the SU's need for 'self-determination'.

There was acknowledgement in the literature that clinicians and SUs are often in conflict. For example,

'Alternatively we might conclude that patients' and psychiatrists views differ for understandable reasons. Inhabiting parallel worlds, each part to the relationship perceives a different reality' ¹⁵⁹
(Second order, psychiatrist and sociologist authors).

'... the issue of incongruence in perspective between the client and worker was discussed as being important in the sense that it established a context for processes such as feeling ineffective or experiencing conflict with the client.' ¹⁴⁸
(Second order, allied professional authors).

However, discussion of solutions or the benefit of aligning needs was absent.

In summary, the analysis suggests that the ambiguity of the purpose (i.e., what, why and how) of TRs creates a challenging context within which relationships in community mental health are conducted. Both SUs and clinicians appeared to be unsure regarding what to expect or have conflicting ideas and agendas. Clinicians have multiple roles: the monitor who seeks engagement; the enforcer of medication; the friend; the expert; the companion. SUs also have multiple potential roles: the patient; the complier; the friend; the partner; the adult; the child. This role confusion, stemming from an ambiguity of purpose, as suggested by the narrative review in Chapter 2, ultimately defines the TRs described in this literature. What is clear is that to understand relationships in community mental health, one must consider both clinicians and SUs as mutually and systemically affecting each other.

4.3.4. Characteristics of Therapeutic Relationships in community mental health

In the preceding section several contextual or structural influences on TRs were outlined. In this section, the resultant characteristics of TRs as presented by the literature will be described. There were three main third order constructs: two relate to an interpersonal dimension between

clinicians and SUs (*(dis)trust*, and *(dis)respect*); one relates to a task dimension i.e., *(shared) decision making*.

For each third order construct the analysis suggested a continuum: one extreme where the needs of the SU and clinician were aligned; at the other extreme, SU and clinician needs were opposed; and in between the two extremes may be situations where there are differing degrees of alignment relating to particular situations or particular needs.

4.3.4.1. *(Dis)Trust*

Trust was one of the key constructs emerging from the CIS. There was clear agreement that a good TR is one characterised by trust. The establishment of trust was linked to the presence mutually agreed goals. Situations where SUs and clinicians had different agendas or needs (see Section 4.3.3) were characterised by distrust, a lack of honesty and a lack of disclosure. Trust and disclosure of symptoms were closely related constructs. There were many examples, where a trusting relationship helped to facilitate symptom disclosure. For example

'He (Assertive Outreach psychiatrist) wants to know about everyday things, not just how are your pills... it is broader. That makes up you know, it's a better relationship and you feel oh, you know I wouldn't mind sharing what I do... But when it was very patronising I just put shutters up'.¹⁵⁷

(First order, SU respondent).

Lack of full disclosure was related to attempts to avoid predicted negative consequences. That is, a distrust of the reaction of the other actor. E.g., psychiatrists protecting their professional selves by not fully disclosing side effects (see ¹⁴⁹).

For SUs, the analysis suggests different types of trust in clinicians. Trust of psychiatrists was associated with an appraisal of whether the psychiatrist would or would not be able to help them – an *agency* trust. Trust of nurses or CCs was associated with a willingness to share personal experience and aspects of life – an *interpersonal* trust. This is a reflection of the types of

roles played by clinicians, but the lack of 'agency' trust with nurses/CCs emerging from the analysis is interesting (and is consistent with the analysis in Section 8.2.3.1). With psychiatrists the trust appeared to be almost parental; with CCs the trust appeared to be more representative of a peer relationship.

Clinicians appeared to expect that SUs should trust them automatically. However, the analysis presented a view of SUs developing trust over time and with reference to particular individuals. Indeed, any view of the overall system was characterised by distrust (for example, SUs talk about reluctance to challenge rulings because of distrust in services¹⁴⁹).

Constructs of respect and empowerment of SUs were closely linked with trust, suggesting the development of trust was facilitated by clinicians who treat SUs as individuals with potential for autonomy. Similarly, for SUs a sincerity of commitment shown through clinician investment of time and consistency was an important pre-requisite in a trusting relationship. Factors that weakened trust included: different goals; poor communication and the use of coercion.

4.3.4.2. *Dis(respect)*

Respectful interactions were characterised as '*person-centred*' and included effective listening, availability, genuineness, continuity, empathy, understanding, and seeing the SU as an individual, not just a patient. When some or a combination of these aspects were missing, the TR was appraised as disrespectful.

'Respectful' relationships were associated with increased partnership working and increased trust. However, it emerged that this was not always achievable. For example, partnership working required clinicians to relinquish elements of their control, something that would be considered difficult in the context of '*Accountability*'.

'It seems likely that anxieties over this (patient-centred approach) reduce with experience and that as they find out how to work with

*patients, psychiatrists learn an increased tolerance for patients who disagree with them.*¹⁵⁹

(Second order, psychiatrist and sociologist authors).

Aspects which undermined *person-centeredness* included: time/pragmatic limitations such as clinician turnover; poor communication skills; and perhaps most importantly, the pressure on clinicians to be accountable. Feeling accountable meant that clinicians may have understood and empathised with SUs, but may not be able to act in accordance with the SU's wishes – which would be interpreted by SUs as demonstration of a lack of respect.

4.3.4.3. *(Shared) decision making*

A key task of community mental health treatment is decision making. Like other constructs characterising TRs, there was a continuum regarding decision making: moving from mutual cooperation and shared decision making (SDM) toward paternalistic decisions, coercion or SU disengagement (see Section 5.1 for a discussion on these major approaches).

Interestingly, more so than other constructs, there was some discussion regarding the contextual influences on SDM. For example,

*'At times, within the context of a generally cooperative relationship, it was judged necessary to be firm with patients, or to confront them with difficult issues that doctors felt were being avoided.'*¹⁵⁹

(Second order, psychiatrist and sociologist authors)

While there appeared to be an emerging consensus that SDM was beneficial, there were few examples of this in practice. Rather decisions made at the other end of the spectrum were more salient in the literature.

A hierarchy of strategies were used by clinicians to influence decisions. Strategies such as persuasion and negotiation were presented positively as there is some level of SU involvement. For example,

'Positive pressures (persuasion and inducement) were not related to perceptions of coercion. Efforts to persuade or induce patients may

*have bothered or annoyed patients but they apparently do not produce feelings of coercion.*¹⁵³

(Second order, psychiatrist and psychologist authors).

Lower order strategies were characterised by less active involvement including the use of pressure and 'formal coercion' such as the use of the MHA. The use of 'pressure' from a clinician was viewed as less problematic than formal coercion as the SU who responds to pressure was making a decision to do so. However, such decisions may not be entirely free decisions, for example, choosing the least bad option. For example,

*'The cooperation that the present authors identified appeared to be motivated by SUs' desire to avoid what they perceived to be the consequences of non-compliance being reprimanded 'the doctor would have a go at me' and the illness recurring.'*¹⁴⁹

(Second order, psychiatrist and research authors)

Such decisions may reflect SUs' understanding of unstated rules of interaction and may not always an indication of empowerment. For example,

*'Perceived coercion was reported by both compulsorily and voluntarily admitted patients. It followed the form of threats of non-physical force or of consequences resulting from disobeying clinicians wishes. Perceived coercion was described by service users as being 'hypnotised' and 'brainwashed' and reactions to perceived coercion were referred to by two people as 'playing the game.'*¹⁵⁰

(Second order, SU and psychologist authors)

Both SUs and clinician authors acknowledged the use of coercion as a failure of the TR, suggesting agreement that TRs are those where decisions are shared and SU are empowered to participate in such decisions. However, from clinician authors, there was a sense of inevitability about the use of coercion or pressures. In this way, 'Accountability' seemed to 'trump' the commitment to SDM. (See Section 11.2 for further discussion of such role prioritisation).

Beyond the immediate damage to the TR, few papers reflected on the potential impact of the use of coercion, for example that such interactions may be causally related to the behaviour it is designed to circumvent.

Watts and Priebe²⁵ were the notable exceptions to this. For example,

*'Visits to participants may continue even when a client explicitly asks for them to be stopped. Often the more a client tries to disengage, the more a team will attempt to contact. This notion of beneficial coercion often conflicts with the principle of autonomy.'*²⁵

(Second order, Social Scientist and psychiatrist authors)

In summary, the analysis suggests an acknowledgement of the potential for negative outcomes in the use of pressure and/or coercion but with a few notable exceptions, there was a lack of reflective observation regarding the need/ethics of such interventions and the impact in the longer term.

4.4. Discussion

The thirteen studies in this CIS of the literature presented TRs as a process affected and driven by a complex series of influences. The most pertinent of these influences appeared to be a lack of clear agreement regarding the goal of interactions. In this context MHS appeared to default to a system which ensured engagement rather than one affecting change. Such a system has ambiguous value. This lack of clarity led to clinicians and SUs performing multiple, and at times, contradictory roles, e.g., clinicians acting as monitor, parent, friend and SUs acting as 'patient' and capable, independent adult. In this overall context, SUs and clinicians struggle to establish beneficial TRs characterised in this literature by trust, respect and SU empowerment illustrated through SDM.

It was clear from this analysis that to adequately describe and understand TRs in community mental health settings, it is important to understand both the overall context and the experiences of each of the actors in the system. These findings suggest that the actors mutually affect each other and together affect the overall system within which they operate. Importantly, it is the *needs* of SUs and clinicians that are fundamental in defining their

experiences. While there was some consensus regarding the types of interactions characteristic of a strong TR, the appraisals of such interactions differed according to the needs of the clinicians and SUs. For example, building trust made SUs feel respected, for clinicians it ensured engagement. In this way, the differing needs and appraisals provides some evidence for the proposal in Section 3.3.2 that clinician and SU-rated TRs may be different or measure different aspects of the same constructs.

Previous research in community mental health on 'needs' has focused on SU needs.¹³⁸ The present findings suggest the understanding of TRs could be usefully extended by further research into the experiences and needs of clinicians. As discussed in Chapter 2, there is a clear theme in UK policy of risk aversion and containment of SUs. The role conflict suggested by this analysis, in particular the construct of '*Accountability*', has clear links to such policy dictates. Clinicians have a need to protect themselves against suggestions of neglect or unprofessional behaviour, and appear in this literature to be responding by taking responsibility for the actions of SU. In doing so, clinicians may limit the opportunities for SUs to self-determine and create feelings in the SU of frustration and disempowerment – aspects that clinicians appear to respond to by asserting further control. This bi-directionality or indeed circularity of influence appears strongly in the literature.

One of the clear constructs that characterised TRs in this analysis was 'trust'. It seems intuitively correct that trust would play an important role, particularly in the delivery and reception of MHS, where capacity may be impaired. However, as noted by Brown and colleagues in a 2009 review,¹⁶² there is a paucity of research examining trust within MHS. The findings from this analysis suggest that trust is fundamental to many of the characteristics of TRs. It is therefore highly surprising that there is such limited research in this area. The present analysis suggests that trust may be developed by open and respectful communication and a sincerity of commitment from clinicians. Similarly, trust may be undermined by poor communication, the use of coercion and having different goals.

Interestingly, the needs emerging from this analysis are primarily interpersonal, e.g., need to be valued and respected. This may be a function of paper selection that is based on interactions but nevertheless, it underlines the importance of the interpersonal in relationships in community mental health and thus validates at least one of the dimensions of Bordin's tripartite model of TR, that of 'Bond'⁸⁸ (see Section 2.4.7). Bordin's Goal dimension is also partially supported by this analysis as the lack of clearly defined Goal appeared to threaten the development of TRs. What Bordin's model doesn't capture adequately and what strongly emerges from this analysis is the systemic/bi-directional nature of the TR. That is, a TR is not static, nor is it determined by one of the actors. Rather, the development of a TR is a process that is (or should be) constantly adjusted and considered and is equally affected by SUs and clinicians. This latter aspect is reflective of Frank's perspectives on TRs⁸⁷ (see Section 2.4) i.e., that the actors influence each other in equal ways. This analysis suggests a further extension by consideration of contextual pressures and role conflict, and in particular the influence of power differentials between clinicians and SUs.

This analysis confirms the lack of clearly defined model of TRs and illustrates how the lack of model or 'goal' undermines the development of TRs in community mental health settings.

4.4.1. Methodological considerations and limitations

CIS is a new methodology with limited directions and explanation. In this context there are several considerations that need to be addressed and explored. Firstly, it is unclear how to analyse papers that are theoretical or opinion based. For example the paper by Mead and Copeland¹⁵⁵ is an opinion piece on recovery: what SUs want and what teams should do to enable them. The authors are mental health SUs themselves but also widely published social scientists - therefore a decision was made to treat the constructs as second order. However, if the authors were not social scientists, one may have been compelled to treat the constructs as first order. The authors of meta-ethnography discussed the benefit of moving away from integrative or aggregative reviews by focusing on the interpretations of the data - or the second order constructs. Opinion pieces

by lay population would be considered first order and therefore there is no framework to include in an interpretive review. Would it be appropriate for example, to include first order constructs from opinion or purely theoretical papers in an analysis that focuses on second order constructs in other papers?

Secondly, the reflexivity and authorial voice that is a requirement in CIS may result in findings that are not transparent or reproducible. There is a need for the author to present findings grounded in data in a convincing and articulate manner, but at the same time to acknowledge the limitations of the analysis and 'their boundedness within temporal, spatial, and epistemological locations'¹⁴² (p1361). In this way, there is a fine line between writing a strong and convincing analysis versus a weak and equivocal analysis.

Thirdly, the inclusion of quantitative papers is one of the points of differentiation between CIS and other forms of synthesis. Yet, the precise mechanism through which quantitative forms of evidence should be included is not clear. If the focus is on the *interpretations* of the authors in the primary study, then is CIS merely *qualitising* quantitative research? And is this valid?

Finally, a distinction is made between first, second and third order constructs. Second order constructs are the understandings or interpretations offered by the authors of each of the primary studies. Often they comprise of a sentence or two to convey a particular theme in the primary data. In order to analyse these second order constructs with those in other papers a summary must be made. For example, in Table 4-1: Example of CIS coding process', the summary of the second order construct might be patient passivity. At this stage, a level of analysis is already made – taking it away from the data. This summary of the second order construct is then used to develop third order or synthetic constructs. So in many respects there is an interim step between second and third order constructs that is not acknowledged in the primary methodology papers.

Nevertheless, CIS is an interesting new methodology. Its strengths lie in its ability to take several forms of primary data and to allow critical analysis of the constructs contained within. The result provides a critical understanding of complex phenomena that is couched in, rather than divorced from, the wider context.

4.5. Chapter summary

This CIS provided further evidence of an ambiguity in the model of TRs for individuals with psychotic disorders in community mental health treatment. Ambiguity created differing needs and role conflicts which in turn led to wide variation in the delivery and experience of treatment for both clinicians and SUs. It is clear that while SUs and clinicians may nominally have similar agendas (e.g., person centred care), their motivations and needs differ and conflict.

The remainder of this thesis provides a description of the collection and interpretation of primary data which further explicates the TR in community mental health. In the next chapter, the 'window' through which the TR will be observed – decision making – will be described.

5. Decision making in Psychiatry and the Joint Crisis Plan intervention

As described in Chapter 1, the TR could be defined as an appraisal of interactions and individuals. As an appraisal can be difficult to observe and measure, one way to assess the TR is through observing interactions. In mental health treatment settings decision making, for example about whether to take or prescribe medication, is central to many interactions. In the context of government policies about involving SUs in decisions about their care⁷⁸ (see Chapter 2), in particular through the CPA care planning process, decision making generally and the CPA more specifically, are important interactions through which to observe and assess current practice and how that reflects the TR.

This thesis specifically investigates a variation on routine care planning: the Joint Crisis Plan (JCP). The JCP attempts to alter the interactions of routine care planning by empowering SUs to make decisions about their psychiatric care in the event of a crisis or relapse situation. As an interaction, the JCP provides a window through which to observe the TR.

In this Chapter, the JCP is placed in context: firstly within major approaches to decision making in psychiatry; secondly, within current care planning practices; and finally, within a group of interventions broadly known as Advance Statements. This chapter has five main components:

1. A brief description of decision making in psychiatry.
2. A discussion of current care planning processes in the UK.
3. A delineation of different types of Advance Statements.
4. The development and procedures of the JCP intervention.
5. Research investigating a link between decision making, Advance Statements and TRs.

5.1. Decision Making

In the broadest terms, there are three main types of decision making in psychiatry: Paternalism, Shared Decision Making (SDM) and SU decisions. A detailed review of each type of decision making is beyond the scope of this thesis, and with detailed accounts already available in the literature,¹⁶³⁻¹⁷² only a brief description will be presented below.

5.1.1. Paternalism

The essential characteristic of paternalism is a lack of consultation with SUs on decisions being made, rather the doctor/clinician makes a decision they believe is best for the SU.^{165;173} Paternalism, as defined, may come in many guises. Compulsory treatment under the MHA may be considered paternalistic as the admitting clinician may consider the SU's views, but ultimately overrides them. Paternalism may be evident in more subtle guises as well. For example, Seale and colleagues¹⁵⁹ examined psychiatrists' strategies for discussing medication with SUs. They found that while there was a rhetorical commitment to more egalitarian models of interactions, many doctors still took decisions or withheld certain information that they felt would hinder their chosen course of action e.g., through providing incomplete information about side effects.

Concerns about paternalistic treatment decisions include^{165;173}: SUs have a right to be consulted, involved and informed about their care; there is a risk of abuse of power; the SU may have valid concerns or information about their experiences that may improve the suitability of the treatment decision made; the SU is the best placed to evaluate the effectiveness and suitability of treatment options; and finally, SUs may not comply with decisions they have no investment in. However, there are occasions when a paternalistic decision is required, for example in crisis situations or those when the SU is deemed to be lacking capacity to make their own decisions. Furthermore, some SUs trust clinicians and thus prefer a paternalistic model.¹⁷⁴

5.1.2. Service user or 'informed' decisions

The SU movement began in the 1960s as a reaction against traditional authority figures and what was considered oppressive psychiatric care.²⁶

SUs sought to redress power imbalances and to have control over their own treatment. In this context, SU or 'Informed Decisions' are the opposite of paternalism and are decisions made by SUs, with or without information provided by clinicians.¹⁶⁵

There are several concerns about SU/Informed decisions: SUs may not have all the relevant information; they may not have capacity to make decisions; they may have capacity, but may make what clinicians would consider to be unwise decisions; and finally, decisions made without the involvement of clinicians may actually be difficult enact.^{165;175}

Increasingly, there are formalised methods by which SUs can document their decisions (see Section 5.3), but also SUs may take decisions about their care in an informal way, e.g., through disengagement or non-compliance with medication. Indeed, the literature suggests that the main concern, from the perspective of clinicians, regarding SU/Informed decisions relates to worries relating to refusal of all treatment (see Section 5.3).

5.1.3. Shared Decision Making

Shared Decision Making (SDM) is a compromise between the two extreme positions described above. Charles and colleagues¹⁶⁵ defined four necessary characteristics of SDM:

- Both the physician and patient are involved in the treatment decision-making process.
- Both the physician and the patient share information with each other.
- Both the physician and the patient take steps to participate in the decision-making process by expressing treatment preferences.
- A treatment decision is made and both the physician and patient agree on the treatment to implement.

Such a model recognises that both clinicians and SUs have relevant and helpful knowledge and experience and therefore the best decisions will be generated from joint working. As discussed in Section 4.3.4.3, research suggests that SDM may be difficult to achieve. For example, one study by Goss and colleagues¹⁷⁶ in Italy investigated psychiatrist's skills in involving

SUs in consultations. The SUs in this study had mood and anxiety disorders. The authors recorded 80 outpatient consultations to investigate the use of 'involvement strategies' such as exploration of problems, discussion of different options to address such problems, exploration of patient preferences for involvement in decisions, and examination of solutions from both a patient and doctor perspective. They found that the majority of psychiatrists showed 'minimal attempt of patient involvement' (p418). As discussed in Section 4.3.4.3, concerns about risk and accountability may be a barrier to SDM.

In summary, this section briefly described the major categories of decision making in psychiatry. While there are situations that may warrant decisions made by either psychiatrists or SUs, the current paradigm, supported by Government policy, is that decisions should be shared.

5.2. Routine Care Planning

As discussed in Chapter 2, the cornerstone of the Government's mental health policy is the CPA, and the recent guidelines promote SDM as part of this process.⁷⁸ However, the success of routine care planning interactions in achieving SDM is largely unknown.

There have been several audits of the CPA since its inception. For example, Schneider and colleagues⁵⁸ conducted a survey of all 183 NHS trusts in England providing MHS in 1997-1998. The survey focussed on involvement of professionals, patients and carers in CPA processes. The authors concluded that the involvement of SUs 'was far from universal'. Similarly, 10 years after the Schneider and colleagues' survey, Rethink conducted a survey of almost 1000 SU in 2008¹⁷⁷ and found that a third of SUs did not feel involved in decisions about their treatment.

Without directly observing the interactions in each care planning session, the assessment of SDM is extremely difficult. Audits assessing attendees at meetings provide some evidence for the involvement of SUs in the care planning process, however, the contents of the actual plans may provide

further evidence of involvement. As part of the CRIMSON Trial (see Chapter 6) the 'Crisis and Contingency' section of over 400 care plans was audited at two timepoints.¹⁷⁸ The results (see Appendix H) suggested that between 52% and 75% of SUs attended the meeting at which their CPA care plan was discussed (note, the actual percentage may be higher, these percentages reflect what was documented on care plans). The content of the crisis section of the care plans was also assessed for 'personalisation', defined as one piece of identifying information about the SU about whom the care plan was written. Only 27% of crisis plans were 'personalised', and interestingly, this was not related to a history of risk including harm to self and others and compulsory hospitalisations; rather the contents of most CPA crisis plans followed a formula such as 'call the duty worker; go to an Accident and Emergency Centre'. There is a suggestion in the literature that clinicians question the value of the CPA process^{51;56} which may provide some explanation for the poor documentation. However, the lack of individualised information in crisis sections of CPA documents does suggest that it is a clinician led process and SUs lack involvement. These findings suggest that true SDM (as defined by Charles and colleagues¹⁶⁵) may be difficult to achieve in routine practice and in processes such as the CPA.

5.3. Advance Statements

Advance Statements (AS) is a collective term for a range of interventions that allow individuals to make a statement regarding their future care at a time when they are well and have capacity to do so.¹⁷⁹ Primarily a form of SU or 'Informed' Decision, AS may provide a framework through which SUs' views can be elicited and thus assist with a key characteristic of SDM – the free expression of treatment preferences. This may be particularly beneficial in situations where power differentials impede free expression of treatment preferences.¹⁶⁵

There are several benefits for AS in mental health care including: providing opportunities for SUs to influence/control their future care;¹⁸⁰ increasing SU involvement in their mental health care;¹⁸¹ improving relationships between SUs and clinicians by increasing trust;¹⁸² protecting both SUs and clinicians

in the event of future crises;¹⁸³ and preventing future crises through careful planning.¹⁸⁴ Despite these proposed benefits, there are a number of issues regularly presented against AS by both SUs and clinicians. For example, SUs have expressed doubts regarding the implementation of the contents of their statements.¹⁸⁵ Furthermore, studies of clinicians' attitudes find that clinicians are concerned SUs will refuse all treatment, or propose treatments that are counter to good practice guidelines.^{165;175;185-187} For example, in a postal survey of 167 psychiatrists in North Carolina, Swartz and colleagues¹⁸² found that psychiatrists were more likely to be in favour of AS if they had fewer concerns regarding malpractice suits and placed high importance on a personal code of ethical practice. Such concerns are common and regularly reported, but as the implementation of AS has been relatively limited they reflect imagined rather than actual encounters.¹⁸²

There are several types of AS, some of which are described below. The key differences between them include: the suggested content; the extent that people other than the SU are involved in their delineation, and also their legal standing.¹⁷⁹

5.3.1. Psychiatric Wills

Psychiatric Wills were first suggested by Thomas Szasz in 1982.¹⁸³ At the time of his paper, there were no formal provisions for patients to influence future care. Using the 'living will' in general medical health care and provisions allowing Jehovah's Witnesses to refuse medical treatment as a moral baseline, Szasz argued that a similar provision should be available to psychiatric patients. He stated,

*'[the psychiatric will] asserts, in effect, that competent American adults should have a recognised right to reject involuntary psychiatric interventions that they deemed may be required in the future, when they are not competent to make decisions about their own welfare'.*¹⁸³

Szasz believed that such a document would protect patients from unwanted psychiatric interventions, but could also protect clinicians from ramifications related to involuntarily admitting (or not admitting) patients.

5.3.2. Ulysses Directives

'Ulysses Directives' are in use in The Netherlands and provide an opportunity for the SU to give specific permission for admission at some point in the future. Critics of Ulysses Directives have suggested that there should be provision for refusal (as well as permission) of admission in certain circumstances and that there is potential for relatives and professionals to coerce SU into developing them.¹⁸⁶ However, a study of the attitudes of SUs and psychiatrists towards Ulysses Directives¹⁸⁶ suggests that, like Psychiatric Advance Directives (discussed below), SUs positively view the opportunity to have some influence over their future. Indeed, the SUs in this study proposed that the directives should be broadened to include other wishes including medication and treatment preferences.

5.3.3. Psychiatric Advance Directives

Psychiatric Advance Directives (PADs) have been studied in America and the UK. The content of PADs varies, but generally includes statements of preferences for future care. In America, PADs are legally binding in many states but do not require clinicians to comply with statements that they believe are outside accepted standards of care provision.¹⁷⁹ In the UK, the new Mental Capacity Act (see Section 2.3.5.1), provides legal basis for components of Advance Directives, namely refusals of specific treatments (see Section 5.4.6).

Research suggests that PADs are: popular with SU and carers¹⁸⁵ and some professional groups;¹⁸⁷ and both the reasons for development and the potential implications are able to be understood by individuals with severe mental illnesses.^{188;189} Conversely, like other AS there are concerns regarding: the implementation of wishes contained in PADs during crises from both SUs and clinicians; the ability of SUs to generate a valid PAD; and questions regarding their impact or relationship to outcome.^{185;185;188-190} An often cited concern of clinicians regarding PADs and other AS is the possibility of SUs requesting unreasonable treatments or indeed refusing treatment altogether.^{175;185;188;189} However, an analysis of the content of PADs developed by 106 outpatients in the US¹⁹¹ showed that in 95% of cases the PADs were rated as clinically useful and consistent with clinical

practice standards. Additionally, analysis of the use of PADs in crisis situations among the same sample¹⁹² over a two year period showed that the content of the PAD was followed in 67% of cases. Thus, the balance of available evidence suggests that PADs can provide useful clinical information that can be implemented in crisis situations.

While there are numerous papers which discuss AS in theory or stakeholder opinions, controlled studies regarding the impact of AS are few. There have been three completed controlled studies: one on Joint Crisis Plans (JCPs) (see 5.4.3.2); one on Facilitated Psychiatric Advance Directives (F-PADs; see 5.3.4); and one on Advance Directives in the UK. The latter study¹⁹³ offered 188 inpatients held under a section of the MHA but due for imminent discharge, the opportunity to develop a type of AS called 'Preferences for Care'. 161 inpatients agreed to participate, 5 were subsequently excluded as they were not discharged from hospital. Of the final sample, 63% had a diagnosis of psychotic disorder. Participants were randomly allocated to the either the intervention group where they were assisted in developing their 'Preferences for Care' in addition to standard care in the community or to the control group who received treatment as usual in the community. At 12 month follow-up, there were no differences between the control and intervention groups in rates of admission under the MHA or voluntary admissions, number of bed days in hospital, symptoms, self-efficacy and satisfaction. By way of explanation for the lack of significant findings, the authors suggested that as the participants were in hospital at the time of consent, they may not have been able to fully understand the reasons behind developing an AS and/or administrative factors regarding access to the plan or lack of keyworker investment may not have been optimal. In an analysis of the study published subsequently,¹⁹⁰ and in contrast to the PADs study, the authors found that of the psychiatrists involved in the SU's care, 71% did not remember the SU's Advance Directive, and 61% did not find it useful.

5.3.4. Facilitated Advance Directives

More recently, Facilitated Psychiatric Advance Directives (F-PADs) have been investigated.¹³⁵ This is a manualised research intervention that

provides assistance from an independent individual to facilitate the development of the PAD; thus ensuring its completion. The clinical team may or may not be included in the discussion. In this study, 469 individuals treated for a psychotic illness in the community were randomly allocated to either a facilitated session to develop an F-PAD or to the control group in which they received information about PADs. Of the intervention group, 27% refused the intervention (i.e., the meeting to develop the PAD). Of the intervention group participants who attended the meeting, 16% did not go on to complete a PAD. This resulted in 61% of the intervention group completed an F-PAD compared to only 3% of the control group. Predictors of completion included motivated help seeking, history of victimisation and older age. Additionally, the development of F-PADs was associated with improved outcomes including working alliance (see Section 5.5). In further follow-up of the same sample¹⁹⁴ the authors found that the intervention group participants experienced less coercive events (including police involvement and involuntary hospital admissions) than the control participants over 24 months.

5.4. Joint Crisis Plans

The Joint Crisis Plan (JCP) is another form of AS originally developed for individuals with SMI. Decided at a time when the SU is well, it is a statement of the SU's wishes about their treatment in the event of a future relapse or mental health crisis. A crucial difference between JCPs and other AS is the requirement for involvement of the mental health treatment team and an independent facilitator.¹⁷⁹ While F-PADs do involve an independent person to assist and sometimes the clinical team, JCPs are the only type of AS that directly *requires* the involvement of the clinical team. The JCP Facilitator is present to ensure that both the SU and the clinical team's perspectives are heard and acknowledged. Crucially, the final content of the plan is the SU's choice. In the development of the JCP, the clinical team are present during the planning sessions to discuss the plan and to help the SU understand the implications of their choices. The final plan is jointly agreed by the team and the SU. The JCP therefore encourages SDM, while

emphasising the SU's perspectives, with an aim to encourage SU empowerment and engagement in their mental health care.

5.4.1. Background of the Joint Crisis Plan

In the late 1980s and early 1990s, in the context of a burgeoning SU movement the first 'Crisis Cards' were developed and circulated by mental health SU groups. The first was a card by 'Survivor Speaks Out' SU initiative and were developed by SUs without consultation from the clinical care team. In 1993, the use of such Crisis Cards was endorsed in the UK by the Department of Health who issued best practice guidelines on their use. Crisis Cards were valuable expressions of SU wishes and therefore empowering for SU, but the impact of these crisis cards was unknown and thought to be limited.

Based on concepts from Family Systems Theory (see Section 2.4), it was proposed that SUs would be more likely to be able to influence the care they received if all parties involved were included in the discussion. This seems particularly true of community MHS with the array of services/agencies, and individuals (both professionals and family members) with complex and different needs involved in a SU's care. From this perspective, a Crisis Card or AS developed by SUs in isolation would have limited or no impact. It was from within this context and theoretical framework that the idea of the JCP was generated.

5.4.2. The development of the Joint Crisis Plan

To develop the JCP (originally called the Camberwell Crisis Card), an investigation of the crisis cards in use at the time was conducted.¹⁹⁵ A telephone survey of UK national SU groups such as Survivors Speak Out, Mind, SANE, and the National Schizophrenia Fellowship (now Rethink) established that Crisis Cards were used mainly for self-management and that there were no data available on the frequency of use or development. The Cards from different groups had a number of common elements. Most cards had a section relating to 'nominees' or an individual to be contacted if the SU was in crisis. Other elements were prescribed medication, self-management techniques, and information about wishes for treatment. The

researchers also referred to practices at Lewisham Social Services which had elements of crisis planning that were not held by the SU, but rather stored on the hospital computer that could be accessed by phone. Their system included a hospital planning sheet which detailed practical arrangements in the event of an admission to hospital, and a financial planning sheet which detailed financial considerations such as rent and benefits in the event of a crisis.

With the assistance of a legal advisor from MIND, who ensured the process was focussed on empowering the SU, researchers brought some of these common elements and new aspects (including provision for advance refusals, discussion of past experiences and triggers for relapse) together to create a 'menu' of options that the SU could choose to include on their plan (see Appendix I). The new aspects were based on a number of theories and research available at the time. Firstly, the notion of enabling SUs to have a strong voice regarding aspects of treatment they would and would not like in the future, for example situations in which the SU would like to be admitted to hospital, and things they would like to happen when they first become unwell. Secondly, aspects of Cognitive Behaviour Therapy such as the discussion of triggers and first signs of relapse, resulted in menu items such as 'things that have and have not been helpful in the past'. The proposed menu included four main sections:

- Contact details.
- Current care and treatment.
- Care in a crisis.
- Practical arrangements.

This menu was taken to a number of SU groups to ascertain the acceptability of the menu and to introduce the idea of a joint plan. SUs at these groups were concerned about involving clinicians in developing the plan and the potential for coercion. To address these concerns, the protocol was refined to include a stipulation that the plan would not be developed when a SU was in hospital or in crisis and the numbers of clinicians involved in the meetings would be kept to a minimum. Additionally, an independent facilitator was included in the protocol to ensure that the contents of the plan would be decided by the SU, rather than clinicians. This menu of

options and completed plan was tested in a small study and then a pilot randomised controlled trial (RCT).

5.4.3. Evidence for the Joint Crisis Plan

5.4.3.1. *The Crisis Card Study*

The first investigation of the JCP was conducted in Camberwell in South West London in 1995 and 1996.¹⁹⁶ In this feasibility study, 106 SUs with at least one psychiatric admission in the previous two years and a diagnosis of a psychotic disorder were invited to develop a JCP; 40% of eligible SUs agreed. The most common reasons for refusal were a lack of insight or an unwillingness to consider the likelihood of future relapses. Those who agreed to participate differed from those who did not on three characteristics: they were more likely to have an affective psychosis diagnosis; they had a history of suicide attempts; and they had a history of 'less than annual' admissions to a psychiatric ward.

At 1 month follow-up, SUs were asked about their experience of developing the plan: 95% had felt able to voice disagreement and 92% said their JCP adequately reflected their wishes. SUs also reported feeling more involved in their care, more positive and more in control of their mental health problem. At 6-12 month follow-up, 93% of the sample was interviewed about their experience of developing a JCP. 73% of those who had experienced a 'crisis' had consulted their JCP and 81% of those who had been admitted during the period had referred to or used their JCP during the admission. Additionally, hospital admission records were reviewed for the year after the JCP was developed and revealed a 30% reduction in admissions.

5.4.3.2. *The pilot trial*

In 2000 and 2001, an individual level, single blind, RCT of the JCP intervention¹⁸⁴ was conducted across seven community health teams in London and one in Kent. Eligible SUs were those registered with a community mental health team, with an admission to a psychiatric inpatient

ward in the last two years and a diagnosis of a psychotic disorder. Exclusion criteria were inadequate command of English, inability to give informed consent and current inpatients. In a similar response to the pilot study, 36% of the eligible SUs agreed to participate. Individuals were allocated either to the intervention group in which they developed a JCP or to the control group in which they received pamphlets relating to MHS.

This trial found that the proportion of those admitted during the 15 month follow-up period was smaller in the intervention group compared to the control but not significantly different (30% vs. 44%, $p=0.07$). However, the proportion of the intervention group who were admitted under a *section of the MHA* was significantly smaller than the control group (12.5% vs. 26.5%, $p=0.03$). Additionally, the mean number of section days for the intervention group was significantly smaller than the control (14 days vs. 31 days, $p=0.04$).

The original goals of the SU Crisis Cards were to encourage SU empowerment. These two studies highlighted that for SUs the process of discussing their history and wishes for the future treatment in a collaborative manner with their clinical team could achieve these goals.

5.4.4. Developing a Joint Crisis Plan.

The JCP is developed over a series of meetings organised and facilitated by the JCP Facilitator.

5.4.4.1. *Role of the Facilitator*

The JCP Facilitator is a mental health professional usually a registered mental health nurse (RMN), who is independent of the SU and the treating team. It is the Facilitator's role to organise the meetings, facilitate discussion during the meetings, and produce the final JCP. The Facilitator has historically been a mental health professional with clinical experience within a community mental health setting. Such professionals have the clinical knowledge to be able to prompt for, and suggest, additional

solutions in the event of the SU or clinical team being unable to think of appropriate strategies, such as increased social support or training activities. Additionally, as current treatments for SMI are largely centred on psychotropic medication, often an area of contention between SUs and clinician, facilitators with professional training and experience of psychotropic medication are well placed to mediate, challenge or suggest alternatives in the event of a medication disagreement between SUs and clinicians.

The independence of the JCP Facilitator is crucial to the development of an appropriate atmosphere to enable a collaborative plan. The Facilitator should ensure that both parties feel equally respected and engaged in the discussion. However, it is possible that with their clinical background and qualifications, SUs may question the true independence of the Facilitators and may be concerned that the clinical team's perspectives and solutions will be given preference over their own. Training, and ongoing monitoring of sessions, is required to ensure that this does not occur and that it is the SU's choice and wording that appears on the plan.

5.4.4.2. The preliminary meeting

The aim of the preliminary meeting is to explain the JCP process to both the SU and the CC and to establish rapport and trust between all parties. At this meeting, the Facilitator presents the SU with a 'menu of options' (see Appendix I).

The preliminary meeting involves discussion of each of the options on the 'menu' and provides possible examples of content the SU may wish to include. This first meeting can be conducted on regular visits or meetings between the CC and the SU, thus limiting the amount of extra time both the SU and, crucially for the engagement of clinical teams in the intervention, the CC. The Facilitator aims to involve the CC in discussion to include them in the process and to establish an expectation that their views and experience with the SU is respected and needed in the development of the JCP.

The preliminary meeting takes approximately 15 minutes, however, it may vary depending on how many questions SUs have. The Facilitator leaves the menu with the SU and encourages them to think about what they would like to include on their JCP.

5.4.4.3. The planning meeting

The planning meeting is organised by the Facilitator at least a week after the preliminary meeting to ensure the SU has had time to think about what they would like to include in the JCP. In practice, due to the busy nature of MHS, it is often a longer period between the two meetings and in the case of long delays between the two meetings (e.g., more than three months), the Facilitator may meet the SU a second time to re-orient them to the purpose of the meeting.

The SU is encouraged to invite a family member/friend to the meeting for support. Other attendees are the SU's psychiatrist, the CC and the Facilitator. The minimum attendees for the meeting to go ahead are the SU, psychiatrist and Facilitator.

The role of the Facilitator in this meeting is to introduce the meeting and set the scene for the discussion, including delineating each attendee's role. This introduction provides an opportunity to emphasise that it is the SU's plan, and their choice of content, and that the team's role is to help them decide a workable and satisfactory plan and to understand the implications of their choices. For the rest of the meeting, the Facilitator's role is to structure the discussion, note the SU's preferences, and ensure the meeting runs to time and to prompt or clarify points as required. During the meeting, the Facilitator aims to establish a friendly and supportive atmosphere to enable a good discussion between the team and the SU, rather than to provide their own views about potential options.

The Facilitator manages the discussion by introducing each heading on the menu and prompting, firstly the SU for their view regarding if and what they would like to include under that particular heading, and secondly, for the team's view on the feasibility and the implications of the SU's wishes. The

Facilitator encourages discussion under each heading and once decided and agreed, they prompt the SU for the wording that should be recorded under each heading. The JCP is written in the first person and with the SU's wording; this encourages SU ownership of the JCP. The SU may choose to include all the headings. Likewise they may choose to include very few of the headings in preference for a simple statement about their wishes.

This planning meeting usually takes approximately 50 minutes. It is preferable to convene a meeting that is separate to regular clinical meetings such as CPA reviews/consultations to enable clear delineation of the JCP as a separate process. However, in the reality of MHS, it can be very difficult to find times when all parties are able to meet. In such cases, the planning meeting may be linked with regular clinical reviews. In these situations, the Facilitator must ensure a clear demarcation between review meetings and the JCP planning meeting as the atmosphere should be quite different with a potential shift in power and established patterns of interaction.

5.4.4.4. Agreement with the Joint Crisis Plan

At the end of the discussion the Facilitator asks both the clinical team and the SU if they are happy with the contents of the plan and whether both parties will endeavour to adhere to it. If everyone is in agreement, the meeting is closed. If, however, there is disagreement, further steps are undertaken. For example, the SU may refuse a particular medication on admission to hospital but the team does not believe that is in their best interests. In this situation, the Facilitator may negotiate with both parties to add in wording to highlight this disagreement. This particular disagreement may not jeopardise the entire plan, and the team and SU may still agree to the overall plan. However, if there is fundamental disagreement with the plan and the team does not feel that they can agree to adhere to its contents, the plan may still be developed, but would be referred to as a 'Crisis Card' to reflect that it is the SU's wishes without the team's agreement.

5.4.5. The completed Joint Crisis Plan

Previous studies of AS have raised concerns about the feasibility of implementing the plans due to issues of accessibility.^{175;185;187;190} To address this, once signed off by the SU, copies of the JCP are forwarded to the SU, the clinical team, and perhaps the SU's GP. An electronic copy may also be stored on the Trust's patient record system – with the SU's permission. This electronic storage ensures maximum visibility of the plan for clinicians, including those familiar with the SU's case and history, and those who are not familiar, such as clinicians working in hospital Accident and Emergency centres.

The JCP is designed to be portable. It is printed on both sides of an A4 sheet of paper, and folds down to a credit card size and a plastic wallet is provided. This design ensures that, should the SU wish to, they can carry the JCP with them and refer to it when necessary. Likewise, in the event of a relapse or deterioration where the SU is picked up by the police, or attends an Accident and Emergency centre, they may choose to show their JCP to explain what is happening to them. (See Appendix J for a fictional example of a JCP).

At 9 months, the SU is given the opportunity to update the plan for any factual changes in contact details, and current care such as medication. If the SU wishes to make any fundamental changes to the strategies agreed with the clinical team, a new meeting would be convened.

5.4.6. Legal standing of Joint Crisis Plans in the UK

5.4.6.1. Advance Statements and Advance Decisions

In the UK, an AS is an expression of a range of wishes, choices, and aspirations concerning psychiatric treatment made by a SU while they have capacity, in preparation for a time in the future when decision-making capacity is lost or they are unable to express their treatment preferences. In this context, a JCP is a type of AS. Some types of AS are binding in law. Advance Decisions (AD) concerning treatment refusals can be. However,

even when not legally binding, AS should be taken into account when making decisions about a SU's care.

As set out in the Mental Capacity Act 2005 (MCA) an AD is a refusal of a specific treatment, made at a time when an individual has capacity, anticipating a time when they may lose decision making capacity. An AD may come in any format (i.e. written or verbal) unless it is a refusal of a life sustaining treatment, in which case it must be in writing, and be signed and witnessed. ADs are considered valid if the person is an adult with capacity and the refusal is specific to the particular situation. Where a valid AD exists it is legally binding. For example, the MHA 2007 has specified that ECT may not be given to individuals if there is a valid Advance Decision in place (see MHA 2007, 27, subsection 5). Treatment contrary to such a decision may amount to the civil wrong of assault and battery. However, an AD may not apply in the following situations:

- Where it does not specifically apply to the situation that has arisen.
- Where it can be shown that the person has changed his/her mind about the instructions shown in the advance decision.
- Where it is not clear.
- Where the MHA provides legal authority for the treatment to be given notwithstanding the person's wishes.

5.4.6.2. The legal standing of Joint Crisis Plans

As it is a statement of preferences and practical arrangements, the JCP may be considered an AS and is therefore not legally binding unless it incorporates a valid AD component. An AD as a component of a JCP is legally binding unless one of the negating situations described above exists. If the SU has an existing AD before making a JCP, it can be incorporated into the JCP and is legally binding. If the SU makes a statement refusing future treatment during the planning meeting, this will be noted in the JCP and, as an AD may come in any format, this refusal will have the same legal standing as an AD.

5.5. Decision making and Therapeutic Relationships

There are some preliminary suggestions that the process of developing AS may have an impact on the TR. For example, a qualitative study of psychiatrist and SU views on Ulysses Directives¹⁸⁶ found that the use of such directives was associated with increased SU trust – a key component of a TR (see Section 4.3.4.1). A review of intervention participants' experiences of developing a JCP in the pilot trial¹⁸⁰ showed that after 15 months a quarter of SUs reported a change in their relationship with their mental health team, whilst 39% of clinicians also reported a change. However, in a study of PADs in Oregon, clinicians reported no change in their relationship with SU.¹⁸⁵

The only published RCT that has investigated the impact of an AS on the relationship between SU and clinical clinicians is the RCT of F-PADs¹³⁵ (see Section 5.3.4). One month after the F-PAD was finalised, the intervention group had improved scores on the WAI; this effect was maintained after controlling for outpatient service contacts. The WAI in this trial was rated by the SU and indicates that an intervention that does not directly address the relationship between a SU and their treatment team nor involve the treatment team directly, but is designed to improve SU's control over their mental health care treatment, could effect SU's appraisals of their care.

In contrast, Hamann and colleagues¹⁹⁷ conducted a controlled trial of an intervention for SDM with inpatients treated for schizophrenia and found no difference on psychiatrist ratings of WAI between control and intervention groups. There were several limitations to the study. The TR was not assessed at baseline so the authors could not control for differential levels of TR between the groups at baseline. The intervention group had longer initial stays before being included in the study and lower levels of pathology as compared to the control group, characteristics that may have influenced the response to the intervention. Individuals were selected for 'suitability' for the intervention, thus making the study vulnerable to selection biases. The authors also didn't collect SU ratings of WAI, which as previously discussed, may represent a different construct of TRs (see Chapter 3).

Nurses conducted the intervention, and then the SU met with the doctor within 24 hours to discuss their decisions. The rating of the WAI occurred at discharge. There was no information regarding the frequency of contact between SU and doctor in the intervening period, nor whether the decisions made were followed.

It is generally thought that SDM and AS, through increasing SU involvement in their own care, will have a positive impact on relationships between SUs and clinicians.¹⁸⁷ The opposite effect is equally plausible. For example, should the SU articulate their preference for a particular treatment and this was not implemented in a crisis situation, there could be a negative impact on the TR. However, the balance of the limited evidence suggests that such interventions may positively influence SU ratings of TR, but are unlikely to effect clinician ratings of TR.

5.6. Chapter summary

This chapter described types and approaches to decision making in mental health treatment.

The brief review of decision making suggests that SDM may be difficult to achieve in routine practice. Audits of the CPA programme suggest that involvement of SUs in meetings and deciding the content of the plan is 'far from universal'. The JCP intervention attempts to address this difficulty by focusing on the SU's wishes for treatment while encouraging discussion with clinicians. In moving towards a model that requires and demonstrates respect for the experience and opinions of both the SU and clinician, the JCP intervention may indirectly address the TR. Few studies have directly investigated the link between TRs and AS or models of SDM, but there are suggestions that such interventions may improve the TR, at least in the short term.

The remainder of this thesis explores this hypothesis using data collected from the CRIMSON trial.

Part II

6. Methodology

In this chapter the overall methodology for Part II of this thesis, the data collection and analysis, will be outlined. There are five main components to this chapter:

1. The design of the CRIMSON trial, within which this thesis is embedded.
2. The aims of data collection and analysis specific to this thesis.
3. The rationale behind the mixed methods approach that provides the overall structure and sequencing of the data collection and analysis.
4. The methods of the qualitative data collection and analysis.
5. The methods of quantitative data collection and analysis.

6.1. The research context: The CRIMSON trial

The CRIMSON trial¹⁹⁸ was an individual level, single-blind, randomised controlled trial comparing the JCP intervention to a treatment as usual control for individuals treated for psychotic disorders in four Mental Health Trusts across the UK. The CRIMSON trial was funded by the UK Medical Research Council and Department of Health and received ethical approval from King's College Hospital Research Ethics Committee (reference 07_H0808_174 – see Appendix K).

The trial recruited participants between August 2008 and March 2010. Participants were followed-up 18 months after randomisation (between February 2010 and September 2011).

6.1.1. Participants

6.1.1.1. Inclusion and exclusion criteria

Individuals with a history of relapsing psychotic illness were recruited. Specific inclusion criteria were: adults (over 16 years of age); diagnosis of psychotic illness as determined by OPCRIT;¹⁹⁹ registered on (Enhanced) CPA

in the last two years; ability to consent; and at least one psychiatric hospital admission in the previous two years. SUs under sections of the MHA were excluded to reduce the likelihood of perceived pressure to participate. No further exclusions were made to enhance the external generalisability of the sample.

6.1.2. Recruitment

Participants were recruited from four Mental Health Trusts across the UK: Birmingham and Solihull Mental Health Foundation Trust; South London and Maudsley NHS Foundation Trust; Lancashire Care Mental Health Foundation Trust and Manchester Mental Health and Social Care Trust; the last two combined to make one site. Participants were recruited from generic and specialist community mental health teams. In each Trust a list of eligible participants was generated by Clinical Studies Officers from the Mental Health Research Network. Research Assistants (RAs) in each site approached the clinical team to arrange a meeting with eligible SUs. In this way, selection biases were minimised.

6.1.3. Power calculation

In terms of sample size, a power calculation was conducted based on a hypothesised reduction of the primary outcome of the trial, i.e., the proportion of SUs admitted or detained under a MHA section. In the pilot trial¹⁸⁴ based in London, 26% were involuntarily admitted to a psychiatric ward over 15 months, equivalent to 30% over 18 months. Routine data for inner city wards in Birmingham and Manchester suggested a very similar proportion of SUs are admitted, on average. Assuming that a clinically important reduction would be to at least halve this, i.e. a reduction in absolute terms of 15% to 15%, 90% power using a double-sided test with $\alpha=0.05$ would require 174 in each arm. For the planned ethnic subgroup analysis where the baseline compulsory admission rate was expected to be higher, an achieved subsample of 91 per arm would give 80% power to detect a difference from 40% to 20%. Given the percentages of SUs likely to be Black at each site (from actual MHA use data), 90 are likely to be found with a sample of 270 per arm, and the minimum achieved would be about 80 with a slight reduction in power.

Loss to follow-up is likely to be about 15% for the interview data so this sample size (270) would reduce to an effective 229 per arm, which would allow standardised effect sizes of 0.3 for the secondary outcomes to be detectable with 90% power. The total to be recruited would therefore be 540, or 180 per centre.

6.1.4. Randomisation and masking

After consent (see Appendix L for information sheets and consent forms) and baseline assessment, participants were randomised to either the intervention or control group, stratified by centre using permuted blocks of randomly varying block size, with equal allocation to the two arms. To ensure concealment of allocation, the randomisation was performed by an online system managed by the Clinical Trials Unit at the Study Coordinating Centre in London. The JCP Facilitators at each site were notified by email of the allocation of each participant. Those in the intervention group were contacted by the JCP Facilitator and arrangements were made to complete the JCP. The RAs conducting the baseline and follow-up interviews were masked to treatment allocation. It was not possible to mask the SUs themselves or their clinicians as they participated in the intervention.

6.1.5. The intervention

The JCP intervention was described in Chapter 5. SUs randomised to the intervention group were contacted to make a JCP in addition to usual treatment (see below). The fidelity of the intervention across the sites was maximised by:

- Week long training of the JCP Facilitators and assessment prior to starting.
- Weekly supervision with one of the developers of the JCP Intervention (Kim Sutherby).
- Quality ratings of each of the JCPs to ensure clarity of content and accuracy of information (Appendix M).
- Ratings of 15 randomly selected recordings of preliminary and planning meetings per Facilitator (five at the beginning, middle and end of the intervention period) using a standardised form (Appendix

N and Appendix O). Any deviations from the model were raised during weekly supervision.

6.1.6. The control group

To determine if the JCP intervention was superior to standard care, a treatment as usual (TAU) control condition was chosen. TAU under the CPA includes requirements that all SUs are assessed, receive a written care plan that includes a crisis and contingency plan, and are regularly reviewed. In most situations, SUs have a nominated CC, whose role is to be the central point for communication regarding the SU and to ensure the SUs' identified needs are met.

6.1.7. Outcomes

The primary outcome of the trial was a reduction in the use of the MHA – that is compulsory treatment. A subgroup analysis specifically looking at the use of the MHA within Black SUs was also conducted. Secondary outcomes examined the effect of the intervention on perceived coercion, engagement, overall costs and TRs.

6.1.8. Trial hypotheses

The CRIMSON trial's hypotheses were:

- The proportion of participants sectioned under the MHA would be significantly smaller for those in the intervention group, compared with the control.
- The proportion of participants admitted to a psychiatric ward would be significantly smaller for those in the intervention group, compared with the control.
- The length of stay on a psychiatric ward would be shorter for those in the intervention group.

6.1.9. Research assessments

Baseline assessments were conducted after written and informed consent was obtained from SU participants. CCs, of consenting SUs, who also

provided written consent, were interviewed soon after the SU interview. Both the intervention and control group SUs and their CCs were followed up by RAs 18 months after randomisation. The SU outcomes measured at each time point are shown in Table 6-1. For CCs, demographic information was collected at each time point in addition to their ratings of the TR, and the SU's level of engagement. Descriptions of the specific measures used in this thesis are provided in Section 6.5.2.

Table 6-1: Measures collected from Service Users

Service Users	Measure/Source	Baseline	Follow-up
Demographics	Self-report	✓	✓
Hospital Use	Records	✓	✓
Service use and costs	AD-SUS	✓	✓
TR	Working Alliance Inventory	✓	✓
Perceived Coercion	Admission Experience Scale	✓	✓
Recovery Style	Recovery Style Questionnaire	✓	✓
Recall of JCP	JCP Usage Scale		✓
Functioning	GAF (researcher rated)	✓	✓
Self-harm and violence	Self-report	✓	✓

6.2. Objectives of Part II of this thesis

As described in Section 1.2, Part II of this thesis had three specific objectives:

- 2.1 To determine how key stakeholders view and understand TRs in community mental health and the barriers and facilitators to the development of strong TRs.
- 2.2 To determine if the JCP intervention affects TRs, and if so how?
- 2.3 To determine if the TR at baseline is linked with outcome at follow-up.

To address the first two objectives, a mixed methods approach using qualitative and quantitative methods was used. The rationale for this approach and the individual methods are described below. The third objective was addressed using purely quantitative methods.

6.3. Using mixed methods

A great deal has been written about the differences and benefits of qualitative and quantitative research methods. Typically, quantitative methods, embedded in the positivist tradition, have been considered the most rigorous or 'hard' form of enquiry.²⁰⁰ Conversely, qualitative research has been considered 'soft' or subjective^{11;200} and as such, has been considered to be lower down the hierarchy of evidence. Many books have been written about the superiority of one over the other; such a dichotomous perspective has meant that historically the two traditions were viewed as opposites rather than complementary methods in the exploration of phenomena.

More recently, qualitative and quantitative methods are being used in combination, that is in 'mixed methods' studies.^{11;201} Most frequently, the two methods have been time ordered – such as using a focus group to generate items for a new scale (defining variables)²⁰² or after a randomised controlled trial to provide some explanation for the trial results.^{200;203} Such designs rarely integrate the results of each form of enquiry and could therefore be viewed as two separate studies, rather than a coherent whole that generates a broader and deeper understanding. A design may have explicitly intended this lack of integration, for example, where the two components are included to answer different questions, however, the two methods and their findings tend to be reported separately and thus possibly lose a depth of understanding that may be gleaned from their combination.²⁰⁴ As Greene states,

'The underlying rationale for mixed-method inquiry is to understand more fully, to generate deeper and broader insights, to develop important knowledge claims that respect a wider range of interests and perspectives'.¹¹(p7)

Much has been written about the difficulty of integrating findings from the two methods. A particular barrier has been a lack of clear guidelines, instruction and exemplars.^{203;204} However, over the last decade, a journal specifically directed to discussing and delineating mixed methods studies,²⁰⁵

has indicated an increasing sophistication in the design and conception of the approach.

6.3.1. The paradigm issue

Much of the debate regarding mixed method studies derives from the epistemological positions of the two forms. Quantitative research aims to be an objective rendering of the real world and is therefore embedded in the positivist tradition. The central tenet of positivistic perspectives on knowledge is that there is a true, objective, and factual reality that is able to be observed, recorded and tested. Positivist approaches suggest that knowledge is able to be deduced from careful processes of hypothesising, identification and measurement within an experimental design.^{206;207} In this way, if using correct and rigorous methods, two independent observers of a well defined question would come to the same conclusion.

Conversely, qualitative research with its focus on individual's views, opinions and understandings of the world is more firmly embedded in the constructivist/interpretive tradition. Constructivism proposes that there is no objective reality waiting to be discovered. Rather, reality is embedded in social processes and interpretation, and is therefore changeable and subjective.²⁰⁸ In the constructivist tradition, multiple realities are assumed and thus different stakeholders in an interaction or process may perceive the situation differently.

Thus at the heart of the quantitative-qualitative debate is the concern that the two forms represent incompatible renderings of the social world, for example subjectivity versus objectivity. Greene outlines three stances on mixing these paradigms: purist, pragmatic and dialectical.¹¹ Firstly, the *purist* stance proposes that qualitative and quantitative are in fact incompatible. Secondly, the *pragmatist* perspective proposes that the two forms are logically independent and can therefore be 'mixed and matched' depending on the question of interest, i.e., 'situational responsiveness'. Thirdly, the *dialectical* position proposes that the two forms are different and this difference must be honoured, but can be complementary as the different forms can be used in combination to give a fuller rendering of a

phenomenon. The difference between the pragmatist and dialectical positions could be summarised as convenience versus deliberate use of the different approaches to generate new insights, with the latter moving back and forth between the two paradigms to generate deeper understandings. Greene advocates a middle position that accepts that integrity of both paradigms but accepts the practical constraints of the research process.

6.3.2. Quality in mixed methods – how to mix

There is general consensus that, rather than isolated, non-integrated use of both paradigms, a good quality mixed methods study should consider the interplay between the two forms^{10;203;209} i.e., more in line with a dialectical position outlined above. Integration can be defined as retaining the integrity of each method but through a set of clearly defined actions, combining the two forms to enable increased understanding of the phenomenon.²⁰¹

Measures of study quality, indicating thoughtful and deliberate consideration of integration issues, include reporting on the priority of methods, purpose of combining the methods, the sequence of methods, and finally the stage at which integration occurs.^{10;202;203;209} *Priority* of one method may include using qualitative research to explain the quantitative findings or vice versa, or giving both methods equal priority, that is, both provide explanation of key aims. Description of *sequence* should include whether the data collection and analysis happened concurrently, or one method first and then the other. *Stage of integration* should describe the nature and timing of integration, for example, whether full or partial, during collection, analysis or interpretation.²⁰⁹

6.3.2.1. Outcome of integration

Before considering the process of the integration, it is useful to consider the purpose or outcome. A distinction has been made between convergence/collaboration versus complementarity.^{201;202} *Convergence/collaboration* designs seek to use the two different paradigms to see if the same answer is obtained. That is, by measuring the

phenomena twice or more using different methods, if a similar 'answer' is obtained, the confidence in the finding is increased. Convergence designs therefore account for biases in methodology to establish confidence in the finding.²⁰¹ *Complementarity* designs use the different methods to obtain a different view of the phenomenon to broaden the understanding.

6.3.2.2. *Process of integration*

One possibility for integration is to collect and analyse the two forms of data separately, and integrate the two in the interpretation phase. This is the most commonly applied 'convergence' design – that is, to see if the two sets of data converge towards a singular finding. In this approach similarities or contradictions in the datasets are only considered at the point of interpretation, and could therefore generate a set of further research questions rather than answer the study's objectives.

An alternative approach integrates the datasets in the collection and analysis phases. One such approach is termed 'following a thread' and is described by Moran-Ellis and colleagues²⁰¹ as follows,

'We positioned all the datasets alongside each other conceptually, and started with an initial analysis of each within the relevant paradigm parameters to identify key themes and analytic questions requiring further exploration. Based on the literature and the original research questions, we picked an analytic question or theme in one dataset and followed it across the others (the thread) to create a constellation of findings which can be used to generate a multi-faceted picture of the phenomenon. This, in effect, is an analysis led in the first instance by a grounded inductive approach but developed through a focused iterative process of data interrogation which aims to interweave the findings that emerge from each dataset.' (p55)

In this way, questions raised in one data set can be investigated, corroborated or explained in another, that is, both convergence and complementarity outcomes could be achieved.

6.3.3. Approach taken in this thesis

This thesis takes a dialectal approach to integrating the findings of qualitative and quantitative datasets, and seeks both convergence and complementarity outcomes as relevant for the main questions. In terms of sequencing, the collection of data occurred concurrently within the trial overall, but at a participant level, the qualitative data were collected after the final follow-up interview to avoid any contamination of the outcome by the qualitative interview/focus group. Similarly, the qualitative analysis was conducted throughout the data collection and finalised before the quantitative analysis to ensure that the qualitative analysis was unbiased by these results. Using a 'following a thread' ²⁰¹ approach, where possible leads or interesting themes arising from one form were followed or investigated in the other in secondary analyses.

The priority of each form differed for each question (see Table 6-2).

Objective 2.1 sought to establish how individual stakeholders in community mental health view and understand TRs, and to uncover the barriers for the development of strong relationships. In this context the qualitative data were given priority (capitalised in the table, as per convention²⁰²), and were followed by examining threads (both for convergence and complementarity) in the quantitative data. For example, if SUs described having control as an important component of a strong TR, elements of coercion as measured by the Admissions Experience Scale could be adjusted for in multivariate analyses to establish convergence. Further, in terms of complementarity outcomes (or broadening the understanding of TRs), elements collected in the quantitative data such as levels of education, gender match with clinician could also be adjusted for in multivariate analyses to determine if they significantly affected ratings on TRs.

Objective 2.2 sought to establish whether the JCP intervention led to significant improvements in TRs, and as such the quantitative data were given priority. Qualitative data were used to establish firstly, if stakeholders described changes in TRs (convergence) and then secondly, how the JCP affected (or not) such changes (complementarity). Secondary

analyses could then adjust for important components of the intervention, reported in the qualitative data, in multivariate analyses (convergence).

Table 6-2: Summary of mixed method approach (Objectives 2.1 and 2.2)

Objectives		Priority Method	Secondary Method	Convergence/ Complementarity
2.1	How do stakeholders view and understand TR and what are the barriers and facilitators to strong TR?	QUALITATIVE	Quantitative	<ol style="list-style-type: none"> 1. Complementarity: demographics and clinical variables not emerging from qualitative data investigated for statistical associations with ratings of TR. 2. Convergence: Categories from qualitative data, tested statistically, e.g., interactional components from qualitative data such as 'control' investigated by testing the statistical association of 'perceived coercion' with ratings of TR.
2.2	Do JCPs affect TR and if so, how?	QUANTITATIVE	Qualitative	<ol style="list-style-type: none"> 1. Convergence: reports of effect of JCP. 2. Complementarity: mechanism of effect in qualitative (also linked with Question 1). 3. Convergence: elements of effect controlled for in secondary quantitative analyses.

The results of the qualitative analyses are reported in Chapters 7-11. The quantitative analyses, and discussion of convergence and complementarity investigations for each objective, are presented in Chapter 12.

Objective 2.3 sought to establish if ratings of the TR taken at baseline could predict outcomes at follow-up. In this context, only quantitative methods were used.

6.3.4. Summary

This section outlined some of the methodological considerations of taking a mixed methods approach to answer the first two objectives of Part II of this thesis. The approach taken was dictated by the questions, and qualitative and quantitative data sets were prioritised accordingly. The 'following a thread' approach was used for data integration for both convergence and complementarity aims.

In the next sections of this chapter, the specific approaches used within each paradigm are outlined.

6.4. Qualitative data

This section provides the rationale for and a detailed description of the methodology of the qualitative component of this thesis. There are four main components:

1. The rationale for the use of qualitative research and aims for the qualitative component.
2. A description of and rationale for a Constructivist Grounded Theory approach.
3. The recruitment of participants and the data collection process.
4. A detailed description of the analytical process followed.

Reflections on the process of conducting the research and analysis and demographics of the sample are described in Chapter 7.

6.4.1. Why qualitative methods?

Typically, qualitative research is defined as a set of approaches to collecting data without statistics or quantification.¹⁶¹ Although some approaches (such as content analysis) now include elements of quantification,²⁰⁶ the main processes of qualitative enquiries involve identifying themes and concepts in data to understand, describe and perhaps explain social behaviour.^{14;207;210}

There are several reasons for using qualitative methods,^{206;210} but those most pertinent to this thesis are:

- defining concepts that are poorly understood.
- understanding processes in social behaviour.
- explaining the 'how' and 'why' of different phenomena.

In this thesis, qualitative methods were deemed suitable as the aims were to understand from the 'insiders' perspective what TRs are like in current community mental health settings, how stakeholders appraise TRs and what aspects define their quality. This is important in terms of gaining the perspectives of those involved, but also in clarifying the important aspects

of relationships in community mental health that potentially distinguish them from those conducted in psychotherapeutic settings. As illustrated in Chapter 3 many of the studies conducted within community mental health have used tools designed with psychotherapeutic relationships in mind. It is possible that the equivocal nature of the evidence base to date is due to 'measurement error'. Thus it is important to understand the elements that possibly differentiate TRs in community mental health from those in psychotherapy. Secondly, the investigation of the JCP intervention and its impact required a detailed understanding of the processes that facilitated/hindered its implementation, and the appraisals of stakeholders regarding its important components. Both of these broad aims lend themselves to the detailed inquiry of qualitative methods.

The aims of the qualitative analyses of this thesis were to:

- Describe how SUs, CCs and psychiatrists feel about the existing TRs in MHS.
- Understand the impact of the JCP intervention on TRs.
- Describe how the JCP affects change in TRs (if at all).
- Understand the barriers to implementation of the JCP.
- Develop a theory of how TRs are developed in MHS.

6.4.2. Grounded Theory Methodology

Often a distinction is made between methodology and methods, with the former being an approach or set of theoretical principles and the latter a set of steps taken to work with the data. In this context, Grounded Theory is a methodology that aims to develop theory and explanation of social processes from the 'bottom up'. That is rather than the researcher imposing their perspectives on the phenomenon of enquiry, the Grounded Theory Methodology (GTM) aims to decrease subjectivity in the analytical process and embed the analysis in the perspectives of the participants. Put simply, the goal is to explore and understand phenomena from the participants' perspectives. Like most qualitative techniques,²⁰⁷ GTM does not seek to test hypotheses or verify theory.²⁰⁹ Rather, the theory, or explanation of process, is developed through rigorous interrogation of the data itself.²⁰⁹

GTM was chosen for this study as the aim was to develop a theory of how TRs are developed and the process through which the JCP intervention affects change - from the perspectives of the stakeholders. Additionally, GTM has a number of well described tools/steps such as constant comparison and theoretical memos that provide rigour to the analytical process. The methodology used in this study was 'Constructivist' in that it accepted that any outcome or theory is an 'interpretation' or product of the research process, as opposed to an objective capturing of the real phenomenon.²⁰⁸

6.4.2.1. Theoretical underpinnings

Positivism and Constructivism

Classical Grounded Theory, particularly as proposed by Glaser leans towards positivism (see Section 6.3.1) by striving to objectively capture reality. Although 'softened' in more recent publications of the methodology (see ¹⁶¹) there is still an emphasis on addressing subjectivity and bias in the process. By contrast, Charmaz's approach to GTM – Constructivist Grounded Theory,²⁰⁸ acknowledges the interrelationship between the researcher and the phenomenon as determinant of both the data collection and analysis. In this way, it is acknowledged that the researcher brings their own experiences, knowledge and skills to the study of phenomena and that these influence and possibly enhance²⁰⁷ not only the analysis, but the design and delivery of data collection.

Symbolic Interactionism

Another theoretical perspective influencing GTM is Symbolic Interactionism (SI). SI, which can be seen as part of the broader constructivist perspective,²¹¹ assumes that meaning is derived from individuals' interpretations of objects (including people), events and situations, rather than responding to stimuli without cognition. Blumer's conception of SI¹³ proposes that all meanings are derived from the immediate interactions between individuals or groups of individuals. Blumer outlined three guiding assumptions:

- *That human beings act towards things on the basis of the meanings that these things have for them.*
- *That the meaning of such things is derived from, or arises out of, social interactions with one's fellows.*
- *That these meanings are handled in, and modified through an interpretive process.*

SI thus presents human behaviour as an action requiring cognition and interpretation, and as such is open to enquiry and explanation. Grounded Theory, with its emphasis on understanding and explaining social behaviour and process, is clearly guided by this perspective.

6.4.2.2. *History of the Grounded Theory Methodology*

GTM was first outlined in the 1960s by Barney Glaser and Anselm Strauss. Their book '*The Discovery of Grounded Theory*'²¹² described their attempts at developing a detailed, systematic methodology to rigorously observe, describe and explain human behaviour and processes. It arose at a time of strong belief in the positivist traditions of objectivity, replication, falsification, and generality, and the increasing criticism of qualitative research techniques that were perceived to lack these aspects.²⁰⁸ The increasing view was that qualitative techniques were prone to subjectivity and were therefore unreliable and of questionable validity. The key elements of GTM were a response to these concerns, and an attempt to reduce subjectivity by focusing on rigorous interrogation of the data itself.

Glaser came from a quantitative background and heavily emphasised systematic and rigorous methodology to decrease subjectivity.^{208;213}

Strauss was more influenced by constructivist thinking and believed that human behaviour and processes were influenced by interaction and thus fluid and changeable. Both perspectives generated a methodology that strove for rigour while uncovering the processes of interaction and agency within human behaviour.

Following the original book, there were a number of further publications and iterations of the methodology by Glaser and Strauss together and

individually. In 1990, Strauss co-authored a text with Juliet Corbin setting out detailed instructions on coding methods¹⁶¹ with four steps (open, axial, selective and process) and a 'conditional matrix' which encourages researchers to think about macro and micro links between codes. This original and subsequent publications by the pair created a divide between Glaser and Strauss. Glaser believed that the detailed coding methods described by Strauss and Corbin risked forcing data into preconceived categories and endangered the notion of 'discovery' and grounding of analysis in the data. Instead, Glaser stipulated three stages to coding (open, selective and theoretical) and a wider conception of links between micro and macro factors. However, both approaches (Glaserian and Strauss/Corbin) have been more recently criticised for their 'positivist' leanings.^{206;208}

Kathy Charmaz²⁰⁸ described a modified GTM that addressed some of these criticisms. In contrast to the 'discovery' ideology Charmaz, uses interactionalist and interpretive perspectives i.e., focussing on the action and processes within behaviour and considering the process of analysis itself as a construction. The analyst is a participant in the process and brings their knowledge of the phenomenon to the data collection, analysis, and theory building. Additionally, she suggested a more streamlined approach to coding and suggested that axial coding (described by Strauss and Corbin) can limit the analyst's interpretation and understanding of the data, and in particular fragment the data too finely and risk a loss of perspective of the wider context.²⁰⁸ Rather, Charmaz suggests that:

'Those who prefer simple, flexible guidelines – and can tolerate ambiguity – do not need to do axial coding. They can follow leads that they define in their empirical methods' (p61).

In these ways, Charmaz created a flexible approach while maintaining much of the rigour of the classic GTM.

6.4.2.3. *Methodology used in this thesis*

Despite the different interpretations of GTM most of the principles are consistent including: bottom up theory generation and coding rather than

fitting predetermined frameworks to the data; concurrent analysis and collection; and testing emerging hypotheses through sampling. The key difference between Charmaz's and the classic approach is the overt acknowledgement that the researcher will influence the process of analysis and data collection (see Sections 6.4.2.1 and 7.3.3 (Reflections on data collection)). Charmaz's approach encourages the analyst to consider their influence and how they have 'co-constructed' the analysis with participants. In this context, a constructivist approach, using the principles of SI, promotes an 'interpretive portrayal of the studied world, not an exact picture of it'(p10)²⁰⁸ and is the approach used in this thesis.

6.4.2.4. *Method*

A Grounded Theory study can be distinguished by the following methods:²⁰⁸

1. *Concurrent data collection and analysis* to ensure testing of ideas emerging from the data.
2. *Open coding* based on the data itself rather than predetermined from literature or prior knowledge.
3. *Constant comparison* between and within transcripts.
4. *Memo writing* to stimulate thinking about the description and inter-relations between codes/categories.
5. *Theoretical sampling* i.e., sampling to test theories rather than achieve representativeness.

Rather than a linear progression through these steps, a Grounded Theory study may repeat these steps in an iterative fashion. The final three in the list are further described below.

Constant comparison

Constant comparison is one of the key methods underlying the analysis process. It requires the analyst to compare within a particular transcript a participant's responses to situations, and secondly to compare these with similar incidents or responses within other transcripts. Similarly it requires comparison of developing codes. For example, does code A capture something different to code B or are they elements of the same phenomenon? This process identifies both similarities and variation in data,

enabling a more sophisticated understanding while immersing the analyst in the participants' understanding of their experience. In later stages of analysis, emerging understanding or theories may be compared to theories outside of the investigated phenomenon to see if these comparisons illuminate aspects of the participant's experience that had not been considered. Comparisons within the collected data (and perhaps outside the data) increase both the understanding of the phenomena from the participants' perspectives and the sophistication of the analysis.

Memo writing

Memos are written throughout the data collection and analysis process and prompt the analyst to consider and write about what is occurring in the data and to develop initial theories to test. Through the discipline of writing about the experience of interviewing or data collection, and initial and later coding, the analyst begins to develop a more sophisticated understanding of the processes within the data. As Charmaz²⁰⁸ stated,

'Memos catch your thoughts, capture the comparisons and connections you make and crystallise questions and directions for you to pursue. Through conversing with yourself while memo writing, new ideas and insights arise during the act of writing. Putting things down on paper makes the work concrete and manageable...' (p72)

Memos can take any form and may be a stream of consciousness initially. Subsequent memos may become more abstract and indicate an increasing sophistication of the analysis. Writing about an initial or focussed code (see Section 6.4.7.1), and considering its variations and contradictions, helps to raise the code to a category – that is, an abstracted rendering or naming of a process within the data (see Appendix P for a memo example from the psychiatrists' data).

Theoretical sampling

Theoretical sampling is one of the defining features of GTM. It comes from the ideology of discovering from the data, rather than imposing preconceived ideas upon the phenomenon of interest. The central proposition is that through concurrent data collection and analysis, the

analyst will generate new questions that may not have been considered at the outset. In addition to altering topic guides, the analyst may specifically recruit particular individuals or groups of individuals that they believe will explicate these new questions and further refine emerging categories. The purpose is not to broaden the demographics of the sample, but rather to recruit individuals who will provide further depth to the categories and ultimately give a thorough explication of the processes of interest (see Section 6.4.5).

6.4.2.5. *Developing a theory*

GTM was originally developed to generate theory, however, many studies that use methods such as constant comparison, stop after coding, making no attempt to generate an explanation for the phenomenon.²¹³ Utilising the methodology in this way leads to description rather than a theory. By contrast a Grounded Theory study aims to generate theory. Strauss and Corbin¹⁶¹ define theory as:

'A set of well-developed categories (e.g., themes, concepts) that are systematically inter-related through statements of relationship to form a theoretical framework that explains some relevant social, psychological, educational, nursing or other phenomenon... a theory is usually more than a set of findings; it offers an explanation about phenomena'(p22)

A theory is therefore, more than a description of or sum of its parts. It adds a layer of analysis and understanding about how the parts are linked and influencing a phenomenon of interest. Charmaz²⁰⁸ contrasts positivist and interpretive definitions of theory. Positivist definitions, linked closely with the scientific method, require explanation and prediction. She states:

'Positivist theory aims for parsimony, generality, and universality and simultaneously reduces empirical objects and events to that which can be subsumed by the concepts'. (p.126)

The output of a positivist Grounded Theory is a 'core category' or single basic process that explains a phenomenon. Charmaz suggests that in this way, positivist theories tend to be reductionist and lose the richness and

variation created by context. By contrast, interpretive theories seek to delve into the complexity and maintain the context in the explanation of phenomena.

6.4.3. Research context and design

This qualitative study was embedded within the CRIMSON trial qualitative component. The aim of the CRIMSON Trial qualitative component was to establish the mechanism of action that might explain a reduction in the compulsory treatment. The original design planned two streams of focus groups with SUs who had made a JCP and their CCs: those who had and had not been sectioned over the follow-up period. In recruiting and comparing those two groups, it was hoped to understand the processes when the intervention had 'worked' and when it had 'not worked'. Six focus groups were planned in each site.

The qualitative study presented in this thesis was embedded within the CRIMSON trial and, as discussed above, was specifically designed to examine the impact of the JCP on TRs. Alterations to the original CRIMSON qualitative design are described below.

6.4.3.1. *Amendments to the initial design and theoretical sampling*

Psychiatrist interviews

After the intervention was underway, and pilot focus groups were held, it appeared that psychiatrists were influencing the process of the intervention, either through difficulty in finding times in their diaries for the meetings or through their active engagement or disengagement in the process.

As discussed in Chapter 5, the JCP process is an opportunity for the SU to discuss what they would like to happen to them in the event of a future crisis or relapse. Involving psychiatrists in the discussion maximises the likelihood of the wishes of the SU being enacted (see Section 2.4.5 on Systemic Therapy). However, should a psychiatrist be a reluctant participant in the meeting, they have the power to undermine the process by not agreeing to the plan, or derailing the process by taking control and

dictating the plan themselves. Likewise, having someone with the authority and position of a consultant psychiatrist listen to and acknowledge a SU's past experiences and wishes for the future could be an empowering experience; however, should the psychiatrist not listen to or acknowledge these wishes and experiences, the meeting could be extremely disempowering for the SU.

Following the approach of theoretical sampling (see Section 6.4.2.4), an ethics amendment was approved (see Appendix Q) for individual interviews with psychiatrists to explore their views and opinions regarding involving SUs in treatment planning, the process of developing a JCP and how the JCP differed from their normal practice and interactions with SUs.

Additional individual interviews

As the process of the trial unfolded, it became clear that the individuals who made a JCP and were sectioned often did not remember the JCP at follow-up interview. Thus there were insufficient numbers for focus groups in each site. Instead, individual interviews were conducted with SUs who had been sectioned in order to ensure a detailed understanding of the processes involved. This amendment was approved by the ethics committee (see Appendix Q).

Furthermore, as the initial stages of the data analysis proceeded, it was hypothesised that factors other than formal coercion may have influenced individuals' responses to and experiences of the intervention. In this context, further theoretical sampling was undertaken to interview individuals with particular characteristics such as being young, and those who had successfully and unsuccessfully used their JCP.

6.4.4. Data collection

6.4.4.1. Focus groups and individual interviews

The initial CRIMSON qualitative design included focus groups only. As discussed above, through the process of the study and using the tenets of

theoretical sampling, individual interviews were added to the design. There are many similarities between the two approaches in qualitative research, for example both have the flexibility to allow participants to guide the discussion (rather than rigid adherence to an interview guide) and both allow the researcher to prompt, probe and clarify responses.²¹⁴ However, often the two approaches are seen as incompatible and as generating different kind of data.

Focus groups are used in qualitative studies for several reasons. Firstly, they can be useful for individuals who may feel intimidated by a one-on-one interview and may find discussion in a group situation less exposing.¹⁴ Likewise, discussions of sensitive topics may be well investigated within a group situation by other participants giving permission or raising issues an individual may not have felt comfortable with in an interview situation.²¹⁵ Additionally, focus groups have been used to elicit the views of marginalised groups.^{14;216} Perhaps most importantly, in exploratory studies, bringing people together with disparate experiences may encourage a widening of discussion and take the group beyond the initial prompts or understandings of the researcher.²¹⁷ In doing so, the group provides their own views of the key aspects of an issue to be discussed and discovered. The interaction between participants is therefore a key component of the focus group and close analysis of interactions can provide additional insights into how and why participants hold particular views.²¹⁴ However, one of the debated aspects of analysis of focus group data is the extent to which one can draw out or report an individual's view versus the group's view. That is, as all the comments offered by individuals are heavily contextualised by the group situation, examining an individual's response without considering the interaction with others in the group may be questionable.²¹⁵

The extent of interaction and consensus making within the group may depend on the extent of group identity or composition of the group.^{214;217} For example, in situations where there are individuals with a strong need to tell their individual story, the results of the focus group may be a series of intertwining personal narratives. This was the case in some of the groups for the CRIMSON trial, particularly with SUs who had particularly salient experiences of either the intervention or of MHS generally and needed to

have their experience heard. In these cases, the interaction between group participants was quite low and the data represent more of a series of interviews (i.e., personal narratives) (discussed further in Section 7.3.3.2).

Individual interviews are often used in research when there is a need to understand the detailed, personal experience of participants. In contrast to focus groups, an individual interview is a dyadic interaction.²¹⁷ The role of the interviewer is to probe, and clarify, and as in the focus group, not actively participate per se, but to encourage the participant to provide a detailed account of their experience. In this way, the data generated from interviews tend to be a detailed personal narrative from the participant.²¹⁴

The use of individual interviews and focus group data and reporting on the differences or interplay between the two methods of data collection in published reports is surprisingly rare. One study compared the data generated from individual interviews and focus groups conducted with the same participants using the same topic guide.²¹⁸ They found that while individual interviews generated a larger range of themes with slightly more detailed accounts, there were no significant differences in the conclusions drawn from both forms. In this way, it may be the depth of information and description that differs, but not the content per se. Another study in feminist research²¹⁶ used both forms of data collection in an iterative fashion. The author states:

'The ideas and themes that emerged from the interviews were carried into the groups, which then generated subsequent themes and ideas that flowed into more individual interviews. I was thus able to test ideas and themes in both methods and bounce them off the groups and individuals.' (p464)

Using a similar approach, the analysis in this thesis used both forms of data collection and rather than treating them as separate forms of data, new ideas from the focus groups were added to the topic guides of the individual interviews and vice versa. In this way, experiences or views raised in individual interviews could be tested in a wider group to ascertain salience, and issues raised in focus groups could be raised in interviews to get more detailed individual accounts of particular phenomena. Additionally, rather

than analysing the data separately, themes from focus groups, particularly where they were obviously informed by the group context, were tested for consistency with individual accounts from interviews, and vice versa. Data from focus groups were thought to be particularly useful in highlighting structural and ideological impacts on behaviour and opinion, whereas individual interviews were expected to provide a more personal account of these phenomena. Therefore, the data generated from the individual interviews and focus groups were expected to complement each other both in terms of highlighting and clarifying aspects to investigate, and by providing different perspectives on each aspect.

6.4.5. Recruitment of participants

6.4.5.1. *Service users*

SUs were only approached to participate in focus groups or qualitative interviews after their follow-up interview had been completed so as not to contaminate the response to the intervention by placing more emphasis on their experiences of the JCP development process.

A sampling frame was initially developed to ensure the recruitment of a diverse sample within the two streams (sectioned versus not-sectioned). After initial pilot focus groups it was decided that this sampling frame should be restricted to only include those who specified that they recalled the intervention during the follow-up interview. Furthermore, the sampling frame was altered in order to test emerging ideas about the data. For example, during early stages of the analysis, it appeared as though there were differing conceptions of the role of MHS and that this may in part be explained by the age of the SU. To test this, younger SUs, or those with fewer years contact with services were actively recruited, in addition to older SUs. Likewise, early in the data collection many of the SUs in the focus groups had not actually tried to use the plan, but those who had tried to use it had had quite different experiences. Those who hadn't used it remained quite positive about the plan. However, to test whether the principle was successful in practice, SUs who had used the plan in different ways were actively sought.

The focus groups and interviews occurred in three phases: focus groups were conducted first, then interviews, then combined focus groups for respondent validation. SUs were invited to attend by letter firstly. Then each SU was called and asked a few questions to ascertain their recall of the JCP meeting and the contents of their plan. If it was clear that they didn't remember enough detail, it was explained to them that they would not be appropriate for the focus group/interview. If they did recall sufficient detail, they were sent further information (participant information sheet and consent form – see Appendix R) and details of the group. A subsequent phone call was then made to clarify any questions and formal consent obtained.

6.4.5.2. Care Coordinators

Team managers of the CCs who attended JCP meetings were contacted to ask for permission for the CCs to attend. Individual CCs were then invited to attend a focus group/interview. In order to facilitate discussion of the impact of the intervention, preference was given to those who were the SU's CC at baseline interview and at 18 month follow-up, however, this was not always possible due to the considerable clinician turnover in the sample.

6.4.5.3. Psychiatrists

Consultant psychiatrists were invited to participate in an interview about their experiences of developing a JCP. Initial contact was via a letter, followed by a telephone call. Interviews were conducted either in person or over the phone and lasted between 20 to 45 minutes.

Interviews and focus groups for all stakeholders continued until no new themes or concepts were raised, that is until data saturation.

6.4.6. Development of topic guides

An initial topic guide was developed after the CIS (Chapter 4), reading of literature surrounding AS and discussions with topic experts. Individual

topic guides were developed for the SU focus groups and another for the CC focus groups, with separate questions in each for or regarding SUs who had been sectioned.

These topic guides were then trialled in London with a group of SUs and separate group of CCs. Following these pilots, and after each subsequent group and individual interview, the guides were reviewed and amended if new ideas came to light. The final version is in Appendix S.

The interview topic guides for psychiatrists, SUs and CCs were based on those of the focus groups, but also included new themes that had become salient during the course of data collection and analysis (see Appendix S).

6.4.7. Analysing data

Each interview or focus group was fully transcribed by an independent transcriber. The transcriptions were then read while listening to the recordings to ensure accuracy. Each reviewed transcript was then read a number of times to immerse the author in the data.

Coding was then undertaken using Constructivist Grounded Theory methods. Charmaz outlines three stages to coding: line by line, focussed and theoretical coding.²⁰⁹

6.4.7.1. Coding

The first stage of coding was to code 'line-by-line'. This was an 'open-coding' process in that it did not impose a predetermined framework of codes on the data, but rather generated codes from the data. This involved reading each line of the transcript and trying to understand what the respondent was saying within context, and to code for processes using 'gerunds' or words ending in -ing. Charmaz provides guiding questions to orient the coding at this stage. For example, *what process(es) is at issue here? How can I define it? How does this process develop? How does the participant act while involved in the process?* By focussing on processes at

a line-by-line level, the coder is encouraged to stay with the participants' experience of the process rather than imposing their own view. Similarly, by focusing on processes, the analysis goes beyond the merely descriptive, but begins to uncover links and interpret conditions and consequences of action. To ensure that important processes were not overlooked, each transcript was coded in this way.

The second stage of coding, called 'focussed' coding, involved raising the initial line-by-line codes to a greater level of abstraction. This involved using the most salient or frequently occurring line-by-line codes or developing new codes to summarise the key processes in the data, and comparing data in one transcript with similar data in other transcripts and coming to an overall code that adequately captured all the examples of a phenomenon. This required 'constant comparison' within the one transcript and across others and regularly going back to the original data to ensure the adequacy of the proposed focussed code. An example of line-by-line and focussed coding is shown in Figure 6-1.

Following focussed coding, the next stage of analysis involved writing detailed accounts of the focussed codes in 'memos', such as notating initial thoughts regarding the codes and what they meant. This process often resulted in changing the name of the code to reflect the developing analysis and going back to the data to ensure its 'fit' and relevance. Memos were then further refined through defining each code, describing its components, the conditions through which the code arose and was maintained in the data – to develop *categories*. An example of a memo is provided in Appendix P.

Figure 6-1: Example of coding from London Focus Group 3

Text from focus group	Initial code	Focused code
No they were very neglectful and when I started to complain towards the end of last year, everybody started pulling their socks up. Some of them...[sigh] with regards to my treatment. And you know if you phoned duty, they don't care, they don't care. You know I've had one stupid cow, sorry one person saying to me er...[...] She said to me oh there's nothing we can do to help you there [name], you know we can't help you at [mental health centre]. And when they do that now I just complain, I just complain, every time. And now what they've said is they're going to let me see a consultant psychotherapist, and then given me this new label from schizo-affective disorder to borderline trait although its not full blown and generalised anxiety disorder. But somewhere along the line, you know when you feel like you're being duped?	Being neglected	Wanting to be cared about
	Needing to complain	
	Lacking care	
	Needing access	
	Being un-helpable	Needing to complain to get attention
	Lacking expertise	
	Taking action	
	Needing to complain	
	Being allowed	Distrusting clinicians
	Acting in response to complaint	
	Inconsistency	
	Being defined	
	Feeling distrustful	

During focussed coding and memoing, an active attempt was made to discover and describe exceptions to the emerging category – that is, examples that differed in some way to other examples. If exceptions were found, all examples were pooled together to see if the divergent example added to the depth of understanding of the category i.e., to see if there was an overarching category that covered all examples and thus added to the comprehensiveness of the category. For example, when working on a memo about 'working collaboratively' there was an example of Psychiatrist B who suggested that developing relationships with SUs enabled him to be more instructive rather than participatory in decision making. This was in stark contrast to most other psychiatrists who proposed that developing a relationship with a SU was a pre-requisite for participatory decisions. The example from Psychiatrist B was initially considered a divergent case, but after further examination of it and other cases, (i.e., through constant

comparison), specifically examining other examples for instances of instruction once relationships were established, the category changed. It was decided that while the other psychiatrists used words to describe being participatory (such as advice giving), they were in fact being instructive through other means (e.g., interpersonal pressure or presenting only one option). In this context, Psychiatrist B helped to clarify the processes through which decisions are made and the difficulty some psychiatrists felt in being truly participatory. The category then was changed from 'working collaboratively' to 'influencing decisions'.

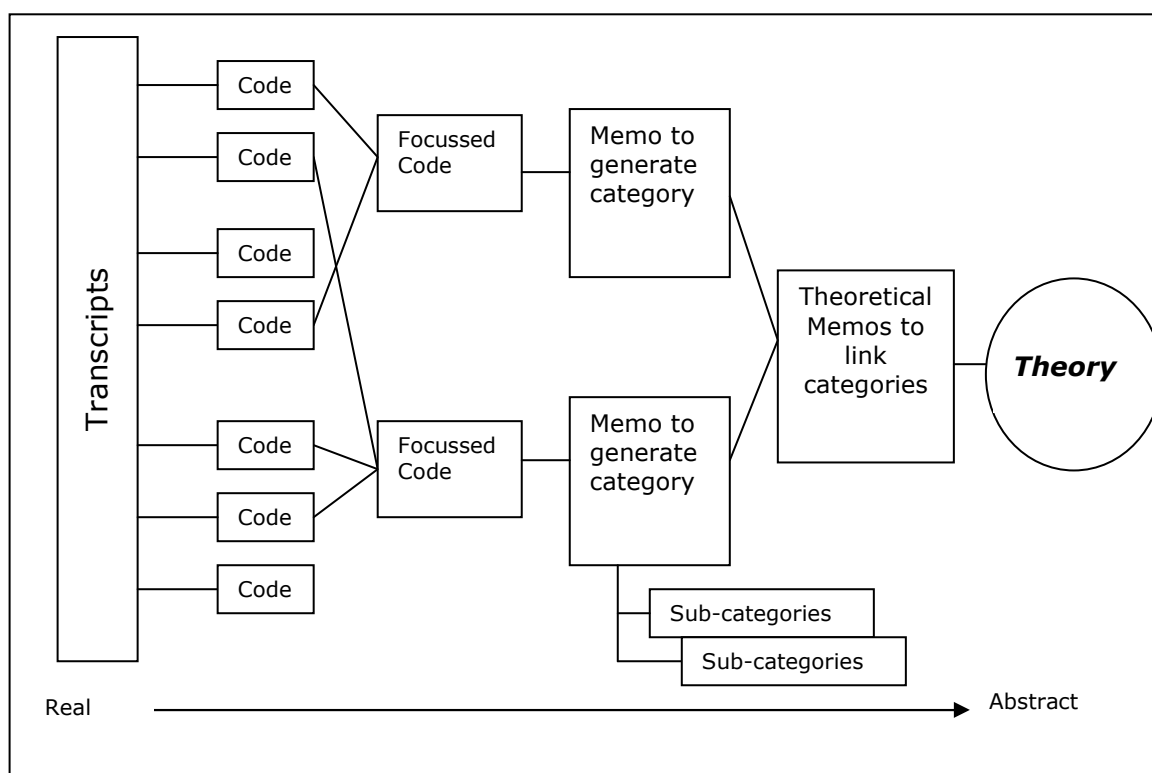
To ensure that each group of respondents' unique views and experiences were captured, line-by-line and focussed coding and memo writing was completed for each group of respondents separately. In this way, and in keeping with Charmaz's view of theory building (see Section 6.4.2.5), the wider contexts of each group and unique experiences were captured and described. Then the most salient categories within and between each group were compared. The final stage, theoretical coding, involved describing the relationships or links between the categories to develop a theory. That is, an explanation for how processes within the data were causally linked or temporally associated with each other. This involved drawing a number of diagrams linking the categories and writing memos to describe the links. A simplified schema of this overall process is shown in Figure 6-2. However the actual process was far less linear than depicted.

6.4.7.2. Validation of coding

In order to ensure the credibility²⁰⁷ of the analysis a number of strategies were undertaken. Transcripts were also read by HL (supervisor) and firstly discussed in high level terms regarding key passages. A selection of transcripts from each stakeholder group was independently coded, compared and discussed. HL is a General Practitioner and Professor of Primary Care with an interest in mental health. There were very few differences between the two sets of codings, but if present the contested section was then re-read, discussed and a consensus was reached. Additionally, developing memos were also discussed with Diana Rose (DR).

As a SU and academic, DR was able to ensure the emerging analysis had resonance with a SU perspective.

Figure 6-2: Streamlined process of codes to theory



NB: adapted from Figure 1.1 in 'The coding manual for qualitative researchers'²¹⁹

6.4.7.3. Respondent validation

Mixed focus groups were held with psychiatrists, CCs and SUs to discuss the emerging analysis. These groups provided an opportunity to clarify emerging concepts and to give respondents an opportunity to re-emphasise points they felt were missed.

6.4.7.4. Determining quality

There are many guidelines for what constitutes quality in qualitative research.²⁰⁷ Most guidelines include tests of quality in the method and reporting of the research, but few include a method to assess the quality of the output of the research – in Grounded Theory terms, the theory itself.

This study used guidelines developed within the Grounded Theory tradition as described by Charmaz²⁰⁸:

- Credibility: having sufficient logical and coherent evidence for the claims made in the analysis.
- Originality: the extent to which the analysis provides significant new insights.
- Resonance: the extent to which the analysis portrays a full account of a phenomenon that makes sense to the participants; and
- Usefulness: whether the analysis has practical implications or uses in the real world.

These criteria guided the analysis and write-up of the qualitative study. In particular, attention was paid to providing sufficient examples from the participants themselves to evidence each category and to consider the implications of the findings within the MHS and the wider academic literature in this area. In terms of *resonance*, this was addressed through the respondent validation and validation of coding described above.

6.4.8. Summary

The aim of this work was to develop a 'mid-range' theory²¹¹ of TRs and the JCP intervention; that is how TRs are developed in community mental health setting and how they influenced the delivery of the JCP. It is a 'mid-range' theory as it aims to describe and explain the interactions between the participants (SUs, CCs, and psychiatrists).

The process of recruitment and data collection for this qualitative component is described in Section 7.3. Descriptions of key categories for each stakeholder are presented in Chapters 8-10. The developed model of TRs is presented in Section 11.2.

6.5. Quantitative study

The CRIMSON Trial was described above in Section 6.1. The quantitative components of the trial that relate to the aims and objectives of this thesis

are presented in this section of the chapter. This section has three main components:

- Power calculation.
- Outcomes and data collected.
- Descriptions of three studies of TR undertaken for this thesis.

6.5.1. Power calculation

In Section 6.1.5 above, the power calculation was described for the overall CRIMSON trial. The proposed sample size would give a standardised effect size of 0.3 for the secondary outcome addressed in this thesis i.e., TRs.

6.5.2. Outcomes and data collected

Participants were seen at baseline and followed-up 18 months later. Information was obtained from interviews with participants and case notes with the SU's permission.

6.5.2.1. *Measurement of Therapeutic Relationships*

TRs were assessed by WAI at baseline and follow-up. The WAI measures the extent to which the CC and the SU perceive a bond and shared goals in their working relationship. The CC and SU version (WAI-CC and WAI-SU respectively) are mirrored versions of each other, for example SUs rate the item "*My relationship with [my CC] is very important to me*" and CCs rate "*This relationship is important to [the SU]*". The original WAI⁹⁷ is a 36-item self-complete measure developed to assess a three factor model of alliance based on Bordin's Bond, Task and Goal theory.⁸⁸ Shorter versions of the WAI (WAI-S²²⁰ and WAI-SR²²¹) have subsequently been published, both indicating acceptable psychometric properties with the WAI-S having direct comparability with the longer version.²²² The version used in this study is based on the WAI-S but was adapted for use in community mental health settings¹³² by adapting the wording from 'sessions' to 'work'. Additionally, in order to minimise the burden in completing the measure and to maximise its applicability to community mental health treatment for individuals with psychotic disorders, items relating the 'Task' dimension were dropped (e.g., '... we agree about the things I will need to do in therapy to help improve

my situation'). This 8-item WAI uses a 5-point Likert scale, ranging from 1 (strongly agree) to 5 (strongly disagree). A total score was generated by summing all the items. The possible range is therefore 8 – 40. Higher scores on the WAI are indicative of weaker alliances. This modified version of the WAI has been used by CRIMSON's international collaborators¹³⁵ who found a significant effect for WAI for the F-PAD (see Section 5.5). Psychometric analysis of this revised scale by the same research group²²³ has indicated excellent internal reliability, similar to those published about the WAI-S. Use of this modified version therefore maximises the comparability of our study findings with similar settings in community mental health and with studies of similar interventions to the JCP.

6.5.2.2. *Other measures*

Other measures collected at both time points that are pertinent to this thesis are:

- *Psychiatric hospitalisations*: information regarding informal and formal hospitalisations in the two years prior to baseline and the 18 month follow-up period were collected from participants' psychiatric medical records.
- *Perceived coercion*: was measured by the SU self-report measure MacArthur Admission Experience Scale adapted for use in outpatient treatment.¹⁵³ It generates three subscales: perceived coercion; negative pressures and procedural justice and is designed to determine the SU's experience of coercion in community treatment. This measure is completed by the SU. Higher scores on each subscale indicate more perceived coercion, fewer negative pressures and less procedural justice.
- *Engagement*: was measured by the Service Engagement Scale.²²⁴ This is a 14 item scale producing four subscales measuring 'availability', 'collaboration', 'help seeking' and 'treatment adherence' and a total score. Higher scores on this measure indicate poorer engagement. This measure was rated by the CC.
- *Overall functioning* was measured by Global Assessment of Functioning (GAF) rated by RAs. Each rating was reviewed by the

author of this thesis. At follow-up, GAF ratings were made before the RAs were unmasked.

- *Demographic information* was collected from SUs (including education, ethnicity, employment and marital status) and their CC (including age, ethnicity, qualifications and length of practice).

All outcome data were collected by the RAs who were masked to treatment allocation. Maintenance of masking and reasons for unmasking were recorded. CCs and psychiatrists in the participating community mental health teams were not able to be masked as they were involved in delivering the intervention. Possible contamination between the trial arms was assessed by reviewing the CPA care plans at baseline and follow-up for all participants to determine if the JCP approach was used with control participants.

6.5.2.3. Implementation of the intervention

The following measures of the implementation of the intervention were collected throughout the trial:

- Reasons for non-completion.
- Time to completion.
- Reasons for delay in completion.
- Context of the meeting (that is if it was conducted within a routine clinical appointment such as CPA review).
- Duration of meetings (however, only for those that were recorded for fidelity purposes).
- Quality of the final written JCP.
- Fidelity to the intervention protocol.
- The attendees at the meeting.
- Contents of the completed JCP.
- SU recall of the intervention at the follow-up assessment.
- SU reported use of the JCP during follow-up period.
- Clinician access of the JCP from electronic patient record systems.
- Mention or reference to the JCP in routine care plans (CPA care plans).

6.5.3. Three quantitative studies to investigate Part II objectives

Three studies addressed the following aspects of Part II objectives:

- 2.1 What are the demographic and clinical associations of SU-rated and clinician-rated WAI?
- 2.2 What is the impact of the Joint Crisis Plan intervention on SU and clinician-rated WAI?
- 2.3 Can SU and clinician-rated WAI at baseline predict clinical and functional outcomes at follow-up?

A priori hypotheses are described in each section. Additionally, for 2.1 and 2.2, and as described in Section 6.3.2.2 on 'following a thread', further analyses were conducted based on the qualitative analyses described in Chapters 8-11.

Multiple tests were conducted. However, as there is no commonly agreed approach to accounting for multiple tests, and possible problems with some strategies such as increasing Type II error²²⁵⁻²²⁷, a decision was made not to adjust for multiple testing. Rather, analyses were treated as exploratory and limitations to results were presented in the relevant discussion areas.

6.5.3.1. *Study one: Associations of Therapeutic Relationships*

Method

This was an investigation of demographic and clinical associations WAI-SU and WAI-CC at two time points: at entry to the CRIMSON Trial and 18 months later. Based on previous research (see Chapter 3), four groups of predictors were examined: demographic, clinical, service provision and service experience. 'Threads' from qualitative research were also examined. All variables are summarised in Table 12-1.

Hypotheses

The hypotheses tested were:

- 1) Demographic variables would be associated with WAI-SU.
- 2) Clinical predictors would be associated with WAI-CC.
- 3) Service provision variables would be associated with WAI-CC.

- 4) Service experience variables would be associated with WAI-SU.
- 5) WAI-CC would be moderately associated with of WAI-SU.

Analysis plan

The dependent variables were SU-rated and CC-rated WAI. To determine if SUs missing WAI data at follow-up differed from those with follow-up data, differences in demographic and other variables were examined using t-tests, chi-square tests and non-parametric equivalents when necessary (see Appendix V).

As an exploratory analysis, all variables were entered into a longitudinal regression – that is using both baseline and follow-up values for the variables to predict the dependent variables. Variables not meeting a conservative threshold ($p < 0.20$)²²⁸ were removed and the regression run again. This conservative critical value for significance was used to account for the possible variance in univariate predictors that was associated with other predictors in multivariate analysis. Excluded predictors were re-entered into the model to test if they became significant with the emerging model.

Results of these analyses are detailed in Section 12.1.3.

6.5.3.2. Study two: Impact of the Joint Crisis Plan on ratings of Therapeutic Relationships

Method

This study used regression techniques to investigate the impact of the JCP intervention on WAI-SU and WAI-CC.

Hypotheses

The following a priori hypotheses were tested:

1. Intervention arm SUs would rate their alliances as stronger (i.e., lower scores on the WAI) than control SUs after adjusting for other predictors of WAI at follow-up.

2. The trial arm of SUs would not affect WAI-CC.
3. Adjusting for 'exposure' of CC would not affect the relationship between intervention arm and WAI-CC.

Convergence investigations of potential mechanisms of effect from the qualitative data generated a secondary hypothesis:

4. A lack of 'consistency' as defined by the length of relationship and clinician non-attendance at the JCP meeting would ameliorate the effect of the JCP intervention for WAI-SU.

Analysis Plan

The impact of being allocated to the JCP intervention on WAI ratings was assessed using multiple linear regression. Two models were generated: firstly, WAI-SU as the dependent variable; and secondly WAI-CC as the dependent variable. Trial Arm was regressed on each dependent variable. Then both models were adjusted for baseline values and site. The WAI-SU model was additionally adjusted for baseline variables associated with missing follow-up data to account for any differential responding to the intervention related to missing data. Secondary analyses were conducted to examine the effect of lack of consistency on WAI-SU. Robust regressions were used to account for any influential outliers. All analyses were conducted on an Intention-To-Treat basis.

Results of these analyses are detailed in Section 12.2.3.

6.5.3.3. Study three: Predictive utility of ratings of Therapeutic Relationships

Method

This study used baseline ratings on WAI (both WAI-SU and WAI-CC) to predict outcomes at 18 month follow-up.

Hypotheses

The hypotheses tested were:

1. A weaker WAI-SU at baseline would be predictive of
 - 1.1. being hospitalised over the follow-up period

- 1.2. being sectioned over the follow-up period
- 1.3. more perceived coercion
- 1.4. self-harm
- 1.5. suicide attempts
2. A weaker WAI-CC at baseline would predict
 - 2.1. being hospitalised over the follow-up period
 - 2.2. being sectioned over the follow-up period
 - 2.3. poorer engagement at follow-up
 - 2.4. poorer functioning at follow-up

Analysis plan

The dependent variable in each model was the relevant outcome. Using linear or logistic regression as appropriate, WAI ratings were entered into the model after adjusting for Trial Arm, trial design (site) and the baseline value of the outcome. To adjust for possible confounding, secondary analyses adjusted for known associations with WAI ratings from Study One.

Results of these analyses are presented in Section 12.3.3.

6.6. Overall summary of methodology

- The CRIMSON trial provides the context of the data collected and analysed in this thesis.
- A mixed methods approach was chosen to enable a deep and broad understanding of TRs and the impact of the JCP intervention (Objectives 2.1 and 2.2).
- A purely quantitative approach was used to ascertain the impact of TRs on outcomes (Objective 2.3).
- Qualitative and quantitative data were collected concurrently during the trial period, but at an individual level, the qualitative data were collected after the quantitative follow-up interview to minimise influencing the effect of the intervention.
- The qualitative analysis was conducted first to minimise contamination of the analysis, followed by the quantitative data

analysis and the following of 'threads' between each data form in order to develop and enrich the understanding of the phenomena.

- A Constructivist Grounded Theory approach was used to analyse the qualitative data to ensure that the analysis was grounded in the participants' experiences rather than imposed from the analysis or trial team.
- Quantitative analyses used multiple regression techniques to: firstly examine the demographic and clinical associations of TRs; secondly to investigate the impact of the intervention and threads from the qualitative analysis; and finally to assess the impact of TRs on outcomes measured at follow-up.

In the next chapter, the recruitment and process components of this thesis are described.

7. Trial Conduct and Sample results

In this chapter, the conduct and recruitment of the CRIMSON trial and the aspects specific to this thesis will be described. There are three main sections to this chapter:

- The first section will describe the CRIMSON trial recruitment and sample that provides the data for the quantitative component of this thesis.
- The second section will describe the implementation of the JCP intervention, addressing the process components outlined Section 6.5.2.3.
- The final section will describe the process of recruiting for and conducting the qualitative data collection.

7.1. Trial recruitment and sample description

7.1.1. The sample

569 participants from 59 generic and specialist mental health teams (70% CMHTs, 16% Assertive Outreach Teams and 14% Early Intervention Teams) provided informed consent and were randomised (see Figure 7-1: Consort Diagram). Recruitment progress over the period is shown in Appendix T. The London and Birmingham sites each recruited 192 SUs. The Manchester/Lancashire site recruited 185. The demographics of the SU sample are shown in Table 7-1.

Data were also collected from CCs for each SU. Demographic data for CCs are presented in Table 7-2. Note that 35/569 CCs did not complete the self-report or demographic questions at baseline.

7.1.2. Follow-up assessments

As presented in the Consort diagram (Figure 7-1) 59 SU participants did not attend a follow-up interview. 504 face to face interviews were conducted resulting in a full data set for 89% of the sample. Reasons for non-

completion of follow-up interview are summarised in Figure 7-1. Data were obtained from patient records for those who had died, were uncontactable and those who refused interview but consented to data being collected from records. 23 individuals refused follow-up interview and also refused collection of data from records. This meant that for those 23 individuals no data were recorded at follow-up. Overall, including full interview and collection from records, data were collected on the primary outcome for 96% of the sample. Further information about missing data is reported in Appendix V.

7.1.3. Maintenance of masking

RAs successfully remained masked to treatment allocation in 92.5% of cases. When unmasked, 70% were unmasked by SUs. In other instances, CCs or members of the SU's family unmasked the researchers.

7.1.4. Contamination

Contamination of the intervention (that is clinicians being exposed the intervention and using the techniques with control participants) was assessed by comparing the CPA care plans for control and intervention groups.¹⁷⁸ There was no evidence of contamination.

Figure 7-1: Consort Diagram

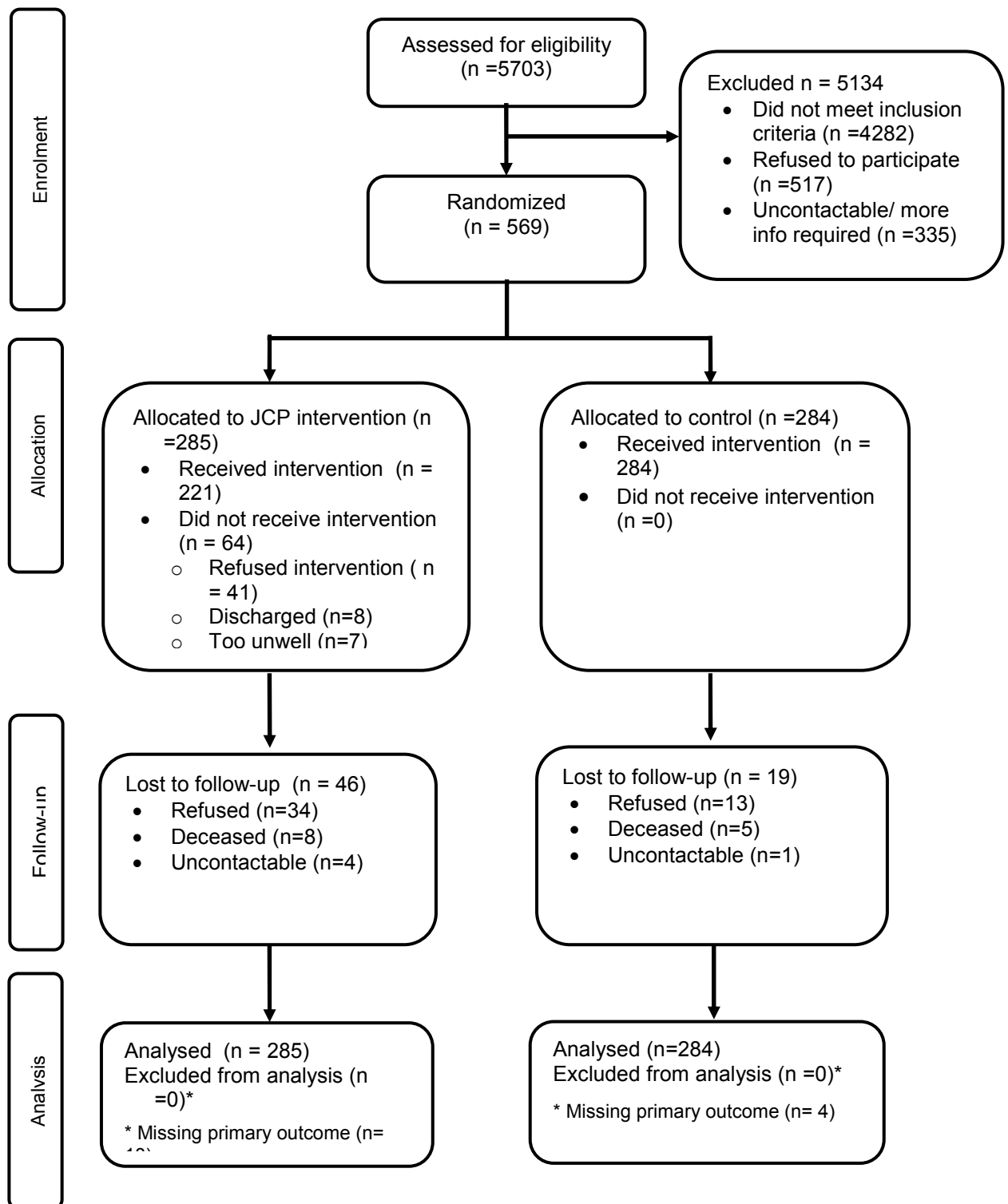


Table 7-1: Demographics of the service user sample

Variable	Category Value	Total N=569, n (%)	Control N=284, n (%)	JCP Group N=285, n (%)
Site	1. Birmingham	192 (34%)	96 (34%)	96 (34%)
	2. London	192 (34%)	96 (34%)	96 (34%)
	3. Manchester/Lancashire	185 (33%)	92 (33%)	93 (33%)
Sex	0. Male	285 (50%)	146 (51%)	139 (49%)
	1. Female	284 (50%)	138 (49%)	146 (51%)
Age	mean (sd)	39.7 (11.9)	39.5 (12.1)	39.8 (11.7)
Marital Status	Married / cohabiting	113 (20%)	62 (22%)	51 (18%)
	Widowed/separated/divorced	107 (19%)	46 (16%)	61 (21%)
	Single	348 (61%)	176 (62%)	179 (60%)
	Other	3 (1%)	0	3 (1%)
Living status	Alone	251 (44%)	122 (43%)	129 (45%)
	Not alone	318 (56%)	162 (57%)	156 (55%)
Nationality	1. English	206 (36%)	104 (37%)	102 (36%)
	2. Scottish	4 (1%)	2 (1%)	2 (1%)
	3. Welsh	2 (0%)	1 (0%)	1 (0%)
	4. Irish	16 (3%)	7 (2%)	9 (3%)
	5. British	256 (45%)	129 (45%)	127 (45%)
	6. Other	85 (15%)	41 (14%)	46 (15%)
Ethnicity	White	353 (63%)	179 (63%)	174 (61%)
	Black/Black British	147 (26%)	75 (27%)	72 (25%)
	Other	68 (12%)	29 (10%)	39 (14%)
Education	None	153 (27%)	67 (24%)	86 (30%)
	School	291 (51%)	158 (56%)	133 (47%)
	Vocational	52 (9%)	22 (8%)	30 (11%)
	Higher	71 (12%)	37 (13%)	34 (12%)
Diagnosis	Schizophrenia Spectrum	422 (44%)	212 (45%)	210 (43%)
	Affective Psychoses	147 (26%)	72 (25%)	75 (27%)
Number of admissions in previous 2 years	mean (sd)	1.49 (0.99)	1.44 (0.88)	1.54 (0.99)
	1 admission	391 (69%)	205 (72%)	186 (65%)
	2 admissions	120 (21%)	51 (18%)	69 (24%)
	3+ admissions	58 (10%)	28 (10%)	30 (11%)
Days in hospital in previous 2 year	mean (sd)	102 (118)	105 (126)	100 (112)
	mode (iqr)	59 (31-129)	55 (31-122.5)	66 (30-132)

Abbreviations: iqr: inter-quartile range; sd: standard deviation.

Table 7-2: Demographics of care coordinator sample

Variable	Category Value	Birmingham (n= 171) n (%)	London (n= 187) n (%)	Manc/Lanc (n=176) n (%)	Total (n=534) n (%)
Sex	Male	44 (25)	62 (33)	83 (47)	189 (35)
	Female	127 (75)	125 (67)	93 (53)	345 (65)
Age	N (Mean (sd))	146 (41.9 (8.6))	135 (44.3 (9.1))	171 (41.7 (8.5))	452 (42.5 (8.8))
Ethnicity (grouped)	White	131 (79)	72 (41.6)	159 (92.4)	362 (71)
	Black/Black British	16 (9.6)	60 (34.7)	4 (2.3)	80 (16)
	Other	16 (11.4)	41 (23.7)	9 (5.3)	69 (13)
Qualifications	CPN	128 (75.3)	110 (58.8)	91 (52.6)	329 (62.1)
	Social worker	25 (14.7)	64 (32.2)	76 (43.9)	165 (31.1)
	Other	17 (10)	13 (9)	6 (3.47)	36 (6.8)
Length of relationship (Months)	Mean (sd)	23.6 (27.8)	22.9 (28.3)	18.9 (17.2)	21.8 (25.1)
Length of practice (Months)	Mean (sd)	172 (120.5)	149.6 (110.3)	144.6 (109.8)	144.6 (109.8)

Abbreviations: CPN: Community Psychiatric Nurse; sd: standard deviation; Manc/Lanc: Manchester/Lancashire

7.2. Implementation of the intervention

7.2.1. Completion rates

221 JCPs (78% of those randomised) were completed across the three sites. The reasons for non-completion are shown in Table 7-3. In most cases it was the SU participants who refused the intervention. However, repeated failure (more than 3) to attend meetings meant that active attempts to convene meetings were stopped and a letter was sent to the participants inviting them to contact the JCP Facilitator if they would like to make a JCP. Likewise, if SUs were too unwell, Facilitators waited until they recovered sufficiently. In nine cases, SUs did not recover in time. There were no differences between sites in the reasons for non-completion. Those who completed the JCP intervention were compared to those that did not. There were no differences in site, sex, age, marital status, living status,

ethnic group, education level or diagnosis. However, those who did not complete had a slightly higher number of admissions in the two years prior to baseline (Wilcoxon rank sum test $z = 2.054$, $p=0.04$).

Table 7-3: Non-completion of the intervention

Reason for non completion	Birmingham	London	Manc/Lanc	Total
Deceased	-	-	1	1
Discharged from MHS	1	2	3	6
Multiple DNAs	2	2	2	6
Refused	15	13	13	41
Sectioned/too unwell	3	2	4	9
Unable to arrange in time	-	-	1	1
Total	21	19	24	64

Abbreviations: Manc/Lanc: Manchester/Lancashire site; MHS: Mental health services; DNAs: Did Not Attend i.e., failure to attend appointments

7.2.2. Time to completion

The intervention was considered completed after the planning meeting was conducted. Dissemination of the JCP usually happened within a day or two of this date. The time to completion was taken from the date of randomisation to the date of the planning meeting and there was a lot of variation, ranging from seven days to 580 days. There was also variation between sites with the Manchester/Lancashire site taking, on average, the longest to complete (see Table 7-4). In most cases the delay was due to difficulties arranging a meeting where all stakeholders were available, particularly clinicians. In some cases, the delay was due to SU factors such as relapses. The capacity of the SU was not officially assessed, but rather the JCP Facilitators, with their clinical experience, in consultation with the clinical team and the SU could decide to postpone meetings if the SU did not seem well enough to meaningfully participate.

Table 7-4: Time to completion

	Number completed	Time to completion (average days)	Time to completion (median days)	Time to completion (min-max days)
Birmingham	75	110	87	7-387
London	77	150	126	33-500
Manc/Lanc	69	230	206	29-580
Total	221	163	126	7-580

Abbreviations: Manc/Lanc: Manchester/Lancashire site

The overall median time to completion was 126 days and was comparable to the time taken in the pilot study.¹⁸⁴ The difficulty encountered in convening the meetings in CRIMSON was partially countered by using existing clinical meetings, such as CPA review meetings (as was permitted in the protocol – see Section 5.4.4). This strategy was also used in the pilot trial, but the frequency was not recorded. In this study, 48% of JCP planning meetings were added on to the beginning or end of the CPA meeting. There was some variation between the sites with 67% of the meetings in London and 23% of the meetings in Manchester/Lancashire added onto a CPA review. The comparatively low percentage within the Manchester/Lancashire site is probably reflected in the longer time taken to complete the intervention (i.e., median of 206 days compared to the overall median of 126 days).

7.2.3. Assessing fidelity

Eighty-one planning sessions were recorded in order to assess fidelity. Of these sessions the average duration of the meetings was 33 minutes (Birmingham 30 minutes; London 34 minutes; Manchester/Lancashire 39 minutes).

In Birmingham and London, one Facilitator completed all the interventions. In Manchester/Lancashire, one Facilitator completed 52/69 (75%) of the JCPs and the remaining 25% were completed by two new Facilitators. The quality of all JCPs was assessed with an average rating of 93%. Fidelity to

the intervention model was assessed in each of the sites at three points during the intervention delivery period for the three initial Facilitators – see Table 7-5. The two new Facilitators in the Manchester/Lancashire site (ML 2 and ML 3) recorded a few planning meetings each with an average rating of 93%. There was consistently good fidelity both across sites for all time periods.

Table 7-5: Fidelity scores at three time points for each site

Period	Preliminary meeting				Planning meeting			
	1	2	3	Average	1	2	3	Average
London	80.2	70	78.6	76.3	79.3	67.6	80.2	75.7
Birmingham	87.5	77.5	77.5	80.8	78.7	86.8	85.1	83.5
ML 1*	85	73.7	77.5	79	85.8	87.3	94.8	89.3
ML 2**							93	93
ML 3***			77.5	77.5			92.5	92.5

Abbreviations: ML: Manchester/Lancashire

Notes:

Scores are a percentage.

* 15 preliminary and 12 planning meetings available; ** 2 planning meetings only; *** 5 preliminary meetings and 2 planning meetings

7.2.4. Attendees at meetings

The attendees at each planning meeting were recorded. The minimum attendees required for the meeting to proceed was the SU, JCP Facilitator and psychiatrist (usually their named consultant psychiatrist). If the SU wished to bring along a friend/carer/family member they were able to do so however, this occurred in only 28/221 planning meetings. In 10 cases there was no named CC (i.e., the SU was exclusively seen in outpatient appointments by the psychiatrist). 148 meetings were attended by the full normal team (i.e., CC and named psychiatrist, or named psychiatrist only where there was no named CC) (see Table 7-6). London had the highest number of JCPs completed with the full normal team and Manchester/Lancashire had the lowest.

Table 7-6: Proportion of plans with full team

	Full normal team n (%)	CC DNA n (%)	Named Consultant DNA n (%)	Both CC and named consultant DNA n (%)
Birmingham	52 (69)	9 (12)	13 (17.3)	1 (1.3)
London	57 (74)	-	20 (25.9)	-
Mancs/Lancs	39 (56.5)	6 (8.7)	22 (31.9)	2 (2.9)
Total	148 (67)	15 (6.8)	55 (24.9)	3 (1.3)

Abbreviations: CC: care coordinator; DNA: did not attend; Mancs/Lancs: Manchester/Lancashire

7.2.5. Contents of the Joint Crisis Plan

As the content of the JCP was the choice of the SU, headings from the JCP menu were only included on the plan if the SU requested them. Appendix U presents the proportion of SUs including each heading, compared to the pilot RCT¹⁸⁴ and pilot study.¹⁹⁶ The most striking difference between the studies is the number of treatment refusals included in the pilot study (74%) compared to the CRIMSON trial (43%). However, the number of treatment refusals included on the JCPs was substantially greater than the number found in the audit of CPA crisis plan documents (see Appendix H) which indicated that only 3% included some form of treatment refusal.¹⁷⁸ These findings are particularly surprising as the Mental Capacity Act, which provides a legislative framework for treatment refusals, was enacted during the CRIMSON trial period.

7.2.6. Recall of the intervention and perceived impact

Once the researchers were unmasked, they re-contacted intervention arm participants to ask them about their experience of having a JCP. Of the 221 individuals who made a JCP, 205 responded to this follow-up questionnaire (15 refused to be interviewed and 1 was not contactable). 167/205 (85%) recalled making a JCP. A slightly higher percentage of people in Birmingham remembered it (81% versus 73% and 72% in London and Manchester/Lancashire respectively) but this was not statistically significant. 20% of those who remembered making a JCP at follow-up, no longer had a

copy of their JCP (75% had lost it; others believed they never received it and one individual was concerned about confidentiality so shredded it). 32/167 (19%) used their JCP in a crisis situation and 28% used it in a 'non-crisis' situation. The most common reason for not using the JCP over the follow-up period was that it wasn't needed (e.g., the SU did not have a relapse).

87% of SUs who recalled the JCP said they would recommend it to others and over 50% (See Table 7-7) of people said they felt more in control than previously (i.e., combining 'much better' and 'a bit better' to make 54%). However, when asked about the impact of having a JCP across several other domains, the most frequent response was that there had been no change following the JCP.

Table 7-7: Impact of the Joint Crisis Plan

	Much better n (%)	A bit better n (%)	No Change n (%)	A bit worse n (%)	Much worse n (%)	Total n (%)
Relationship with team	26 (15.6)	34 (20.4)	98 (59.0)	5 (3.0)	3 (1.8)	166
Care from team	22 (13.2)	30 (18.0)	105 (62.9)	7 (4.2)	3 (1.8)	167
Satisfaction with care	34 (20.3)	41 (24.5)	80 (47.9)	5 (3.0)	7 (4.2)	167
Feeling in control	37 (22.3)	53 (31.9)	68 (40.9)	4 (2.4)	4 (2.4)	166
Feelings re engaging with team	32 (19.3)	36 (21.7)	87 (52.4)	4 (2.4)	7 (4.2)	166

7.3. Qualitative study conduct

This section of the Chapter details the process of conducting the qualitative component of this thesis in terms of recruitment and data collection.

Subsequent chapters will detail the findings for each of the key stakeholders, and the mid-range theory of TRs and how the JCP intervention interacts with TRs.

7.3.1. Recruitment

7.3.1.1. Focus groups

Twelve focus groups were held across the three sites between 21 June 2010 and 21 November 2011. Overall, 58 individuals (including SUs, CCs and one psychiatrist) attended (see Table 7-8). A combined group was held in two of the sites in November 2011. These groups were attended by individuals who had previously participated in an interview or focus group. The primary aim of these combined groups was respondent validation of the developing analysis. At these two groups there was no disagreement and therefore it was deemed unnecessary to conduct a third.

Table 7-8: Numbers attending focus groups by site

	Attendees	London	Birmingham	Manc/Lanc	Total
Pilot	SUs	7			7
	CCs	5			5
Non-sectioned stream	SUs	6	6	6	18
	CCs	6	2	4	12
Sectioned stream	SUs	4			4
	CCs	2			2
Validation	Combined	5	5		10
Total		35	13	10	58

Abbreviations: CCs: care coordinator; SUs: service users; Manc/Lanc: Manchester/Lancashire

7.3.1.2. Individual interviews

Initially, individual interviews with SUs and CCs began in response to the low numbers of sectioned participants who remembered the JCP at follow-up. Individual participants who had been sectioned over the follow-up period and remembered the JCP intervention were invited to a one-on-one interview. The initial selection criteria were then expanded to address themes and questions that emerged from first stages of the analysis. In total, 16 SUs and 6 CCs participated in one-on-one interviews between September and November 2011 (see Table 7-9). All those who were invited agreed to be interviewed.

Forty-one psychiatrists who participated in at least one JCP planning session were invited by letter to participate in a short interview. Of these, five were no longer in post or on long term leave. Fifteen psychiatrists of the available 36 (41%) agreed to be interviewed between February 2010 and June 2011.

Table 7-9: Numbers attending individual interviews by site

		London	Birmingham	Manc/Lanc	Total
Coerced	SUs		2	2	4
	CCs	1	2	1	4
Other	SUs	3	7	2	12
	CCs		2		2
	Psychiatrists	5	4	6	15
Total		9	17	11	37

Abbreviations: CCs: Care coordinators; Manc/Lanc: Manchester/Lancashire; SU: service user

In total, therefore, 15 psychiatrists, 45 SUs and 25 CCs participated in the qualitative component of this thesis (i.e., not counting those that attended the combined focus groups as they are repeats).

7.3.2. Qualitative sample characteristics

SU participants were 52% female, had an average of 39.2 years of age (9.6 sd) and 64% were White. These SU participants were representative of the wider sample. CCs were 58% female, with an average age of 43.8 years (sd: 8), and 75% were nurses. There were slightly more male CCs and more nurses as compared to the overall CC sample at baseline. For the psychiatrist individual interviews, 20% were female, with an average of 6.5 years (range 3-11 years) as a consultant. 26% were involved in research, the remaining having purely clinical and administrative/managerial duties. All interviewed psychiatrists participated in at least one planning meeting (range 1-7; average 4).

7.3.3. Reflections on data collection

7.3.3.1. *Reflexivity – the influence of the researcher*

As discussed in the preceding chapter, there is growing acknowledgement within qualitative research about the influence of the researcher in the development of the topic guide, the delivery of the questions and the interaction of the participants. This is particularly acknowledged in the constructivist tradition. While Constructivist Grounded Theory acknowledges the influence of the researcher, it is still vitally important to minimise the subjectivity in analysis and to ensure that the final theory and categories are representative of the participant's views. The following strategies were used to minimise subjectivity/examine the influence of the researcher: firstly, interviews and focus groups were discussed with HL/DR and impressions were discussed and noted in a field diary; secondly, a selection of transcripts were co-rated with HL and memos were discussed with DR to ensure the validity of interpretations; and finally, the combined focus groups were conducted to test the emerging analysis with the original participants to ensure its coherence with their experiences.

Additionally, during the period of data collection field notes were written. This was a useful process which prompted the author to reflect on their influence on the data collection. In the following section, a summary of some field notes is presented. These notes illustrate reflections and subsequent alterations/insights to the data collection and analysis. (The first person is used in this section).

Reflections from field notes regarding psychiatrists

I travelled to each of the sites to interview the psychiatrists in person. In one interview, I was welcomed into the office of a psychiatrist and instructed to sit on a very small chair (similar to a child's chair). This chair was at one end of a circular table. The other side of the circular table was the psychiatrist's large desk which he sat behind in a large executive style chair. My eye line was just over the top of his desk and his head was approximately a metre above my own. We were approximately three metres from each other. I had to sit up on the edge of the chair, looking up at him at an odd angle and project my voice in order to be heard. He described

that he saw SUs in his office in this manner. I was struck by the strong distance both horizontally and vertically between us and the effect this had on my interaction with him. I found myself feeling more deferential than usual and made a note to reflect on how a SU, particularly one that was unwell, would feel in the same situation. It struck me that such non-verbal communication and manner of interactions were vitally important in terms of how individuals felt when interacting. I resolved to think about the ways in which things are said in addition to the content of what is said.

I also felt that initially many of the psychiatrists were responding to my questions in a manner that they deemed socially desirable – that is, praising the JCP intervention and verbally committing to promoting SU choice. I felt that perhaps they perceived an investment in the JCP intervention/SU empowerment in the manner in which I asked the initial questions and follow up questions. I reviewed my topic guide and listened to recordings to pick up on any overt/covert displays of political views, but did not detect anything that was leading or clearly displaying bias. However, I resolved to clearly articulate my evaluation role in the CRIMSON trial and to emphasise my views regarding the importance of an evidence base for interventions in mental health. Additionally, I noted that some psychiatrists were clearly very uncomfortable about being audio recorded initially, and once they had relaxed a little in the interview situation or indeed the recorder was turned off, their responses were often more candid. These uncensored descriptions were telling and I concluded that rather than a response to their perception of my biases, their discomfort and socially desirable responses illustrated the pressures they felt in terms of maintaining ‘face’ of the profession as one that is professional, expert and reasonable.

7.3.3.2. Further reflections – group membership

As discussed in Chapter 6, one of the key aspects of focus group data collection is the interaction between participants – the generation of shared understanding or meaning. Focus groups can generate disparate views from individuals and then through discussion and challenge generate a consensus view. However, as alluded to in the preceding chapter, there was only limited interaction in the focus groups with SUs. With the

exception of discrimination within MHS as indicative of poor TRs, the participants in focus groups did not differ, nor challenge, nor discuss amongst themselves aspects of the experience of the JCP. There are several possible explanations for this. Firstly, they didn't share sufficient group identity, for example, in an early focus group one SU participant interrupted and asked everyone whether they had depression and thus highlighting that they didn't immediately identify with the others in the group. Secondly, the interactions that did occur in the SU focus groups were more about treatment from MHS and needing to fight or 'play the game'. There was a shared understanding of this process, but not of the JCP. In this context, it is possible that there was insufficient recall of the JCP experience or it wasn't deemed as important as other aspects of their experience in MHS.

7.3.3.3. Recruitment issues

Recruiting CCs to focus groups and individual interviews was very difficult. This was particularly the case in Birmingham where three focus groups were arranged and cancelled due to last minute cancellations from CCs or insufficient numbers agreeing to participate. In Birmingham individual interviews were conducted with four CCs. However, the difficulty in arranging both the interviews and the focus groups is instructive and speaks to the lack of engagement in the process in Birmingham. This was not the case in London and Lancashire, where CCs were more positively engaged in the idea of the intervention and this was true of their responses to the actual delivery of the intervention. This experience of difficulties/poor engagement in Birmingham of CCs is consistent with the findings detailed in Section 7.2.4 regarding the numbers who did not attend the JCP planning meeting - the highest non-attendance of any of the sites. In this context, the positive responses to the intervention expressed by CCs in this sample may not be entirely representative of all CCs who were exposed to the intervention. To account for this, negative views were actively sought and highlighted in the analysis described in the following chapters.

7.4. Chapter summary

569 individuals with psychotic disorders were recruited across three centres. The follow-up rate of the sample 18 months later was strong with 88% full outcome data and 96% primary outcome data obtained. Methods employed reduced the risk of selection and allocation biases, the effects of which can be seen in the even spread of demographics characteristic across the intervention arms. The large proportion of outcome data obtained and the maintenance of masking of RAs suggests very low risk of attrition and detection bias. In this context, any differences detected could be reasonably assumed to be the result of the intervention.

The JCP implementation was delivered with fidelity and quality. The rate of completion of the JCP intervention was very similar to the pilot RCT¹⁸⁴ and there were no significant differences in rates of completion and reasons for refusal between sites. There was an unexpectedly high usage of existing clinical meetings (rather than dedicated JCP meetings) and this was slightly higher in the London site. Similarly, there were moderately high levels of meetings that proceeded without the full clinical team. These two latter points (use of clinical meetings and absences in the clinical team) were not part of the protocol and therefore were not issues of fidelity as defined by the trial team. Rather, these issues are representative of the difficulties implementing a research intervention in routine practice and perhaps suggest a possible lack of interest from clinical teams in the trial. However, as will be seen in Chapters 8-12, these factors had a significant effect on the appraisal of the intervention.

Forty-five SU and forty clinicians participated in the qualitative component of this thesis. Efforts were made to reduce subjectivity and influence of the researcher in both the data collection and analysis. There was some difficulty recruiting clinicians to the qualitative component. It is possible, therefore, that those with more negative views regarding the intervention were not captured in this analysis. To counter this, negative views were actively sought in interviews and focus groups and were carefully attended to in the analysis.

In the following chapters, the findings of the qualitative analysis for each stakeholder and the theory generated regarding TRs in community mental health treatment settings are presented.

8. Service User views on Therapeutic Relationships and Joint Crisis Plans

This chapter presents findings from the Constructivist Grounded Theory analysis (see 6.4.2.3) of SU focus groups and individual interviews, and is organised around four major categories that cover pre-cursors, expectations and effects of TRs in community mental health. The presentation of each category has two main components. Firstly, each category and its subcategories will be described. Secondly, the aspect of each category that was affected by or interacted with the JCP, and thus provided further explanation of the category, will be detailed.

The four major categories, their subcategories and interaction are shown in Table 8-1: Summary of service user categories. The numbers in Table 8-1 refer to the section in this chapter in which the category is described in detail. For example, the sub-category 'Clinicians doing their job' is described in Section 8.2.3.

Table 8-1: Summary of service user categories

SU Categories regarding TRs	Interaction with JCPs
8.1: Understanding the past 8.1.1: Being treated badly	8.1.2: Controlling my story
8.2: The building blocks of TRs 8.2.1: Being known as an individual 8.2.3: Clinicians 'doing their job'	8.2.2: Being heard 8.2.4: Holding clinicians to account
8.3 Having status – understanding my place in the system 8.3.1: Feeling disrespected by others 8.3.2: Distrusting myself	8.3.3: Modelling acceptance
8.4: Being in control of my experience 8.4.1: Influencing change	8.4.3: Ensuring reasonable treatment

8.1. Understanding the past

A regular theme of discussions in both the focus groups and interviews, were SUs' descriptions about difficult or disappointing past experiences in mental health care. The individuals in this study had an average of 15 years contact with MHS and had many stories of past experiences that were either traumatic, deeply disappointing or 'counter-therapeutic'. To a lesser extent, and only within the focus groups, there were discussions about feeling discriminated against within mental health care and the wider community. These experiences formed a basis from which new relationships or interactions were perceived – and are therefore a precursor to the development of TRs.

8.1.1. Being treated badly

SUs described many positive experiences within MHS, however, it was the experiences which were interpreted as poor treatment that were defining in terms of their interactions. '*Being treated badly*' is therefore a sub-category of '*Understanding the past*'. As one woman in London said:

"The thing about when you're consistently treated badly is you expect to be treated like that so it doesn't... you're sad about it but it doesn't, it's what you're used to."

(Female, London Focus Group 3)

'*Being treated badly*' as described by this woman related to the interpersonal interaction with a psychiatrist who had his back turned to her and read unrelated emails during her JCP planning meeting. In this context, rather than feeling entitled to be shown respect, the woman's response was to accept this behaviour, it confirmed for her that she didn't deserve better treatment. Reluctant acceptance of such treatment was common and seems to have resulted from years of being shown and told that one is unwell. This concept is discussed further in Section 8.3.

Other examples of poor treatment related to aspects of unreasonable or counter-therapeutic treatments. One woman described a situation where her psychiatrist reduced her medication after her mother had died which resulted in a relapse and traumatic hospital admission,

"And my doctor stupidly reduced my injection at the same time that my mother had died, just before Christmas, and I ended up in hospital from that Christmas 2006 right until, erm...July 2007. [...] They just come and they got an ambulance, and drove right over the grass to my flat and they just dragged me in to hospital. It wasn't even thought about it, it was just that one day I was fine and the next day I was in hospital."

(Female, Birmingham Focus Group 1).

Some SUs described changing their behaviour towards clinicians due to past negative experiences. For example,

A Well I've had my problem when I was 21, over 10 years ago... At first I used to tell them everything you know. But then as time went on I lost trust in them, to the point where, as... you know as time went on it went worst and worse. Nowadays I don't treat them as normal people you know. You know, at first I was very trustful and it just got worse and worse as you get older.

R Why did it get worse?

A Because I felt betrayed and stuff, like... you know like, like I said before they can be very funny people you know, like tease you and stuff like that.

(Male, Lancashire Focus Group 1)

Negative experiences of interactions and poor treatments in the past appear to be fundamental in defining both SUs' internalised representation of their place in MHS and their level of expectation and trust of MHS. In particular, treatments that were viewed as counter-therapeutic led SUs to question clinicians' expertise and distrust future treatment recommendations. In this context, developing and maintaining an honest and trusting TR required clinicians to understand what has come before and what impact those experiences may have on current and future experiences.

8.1.2. Interaction of 'Understanding the past' with Joint Crisis Plans:
'Controlling my story'

One of the aspects of the JCP that SUs valued was the opportunity to both tell and control their story. 'Controlling my story' was a sub-category of 'Understanding the past'. There were two components to 'Controlling my story': firstly SUs ability to describe their past experiences; and secondly the ability to control the narrative of past and future experiences and how they were known. 'Controlling my story' was therefore about being able to determine what was said, how it was said, and who hears what was said.

The JCP provided an opportunity for SUs to tell their story in their own words and for clinicians to hear this version of events. SUs described experiences where a professional's narrative in the past had differed from their own. Having things told or written about them that they did not agree with was deeply unsatisfactory to many SUs. For example,

A *They did some kind of care assessment thing from the hospital. Don't know where it is but it wasn't good it was just, it was when I kicked off on the ward. I wasn't happy and was accused of smoking crack and it wasn't me. But anyway I went a bit mad in the hospital and the police turned up and stuff like that. And I was arrested and they put it in, somebody's given them the intelligence that I've had access to guns and knives and stuff like that. Which was a load of shit, it was just a load of crap it was. So I didn't like that at all, I was upset about that.*

R *Yeah I can understand that. So did you say they documented that on your care plan?*

A *Oh I yeah, they documented it. I think they were trying to hold back from giving me [the care plan] at first. But now they've given it to me and it's just like...you know a bit pissed off with it.*

R *I can understand that if it's er, an official document and there's stuff that's*

A *... not true.*

(Male, Manchester, Individual Interview)

For some, the JCP provided an opportunity to control what was said about them in an official document. SUs believed that having this information officially recorded would mean that they wouldn't have to repeat their history for each new clinician they encountered. The JCP provided a summary of the important points of their history, and enabled clinicians to understand what they needed and get them help quickly. However, for many SUs, this didn't happen. For example, one woman described trying to use her JCP late one evening when she was in a crisis,

"I thought that the JCP was there so I didn't have to go through all the beginnings. They would know exactly who I was, they could get me up on the computer, it was everything there about me, what psychiatrist I'm under, what my highs what my lows, it's all there, it's all there in front of them. So why should I have to go to my GP for him to say well yes you are, you have got bipolar you're not very well. And then go on to the next stage, oh we'll take you to hospital and we'll see a psychiatrist there and then we'll decide what we're going to do with you. I thought that I didn't have to do that, I'd got my JCP so the mental health [services] knew about me. It was there it was important, to help me get help when I needed help."

(Female, Birmingham Individual Interview)

Other SUs reported that clinicians didn't know about the JCP or did not refer to it in crises.

In summary, the JCP appears to have assisted SUs in controlling what is said about them in terms of what was discussed during the JCP meeting and what was recorded on the final JCP. However, the JCP appears to have been less successful in allowing SUs to control their future (see Section 8.4).

8.2. The building blocks of Therapeutic Relationships

The second major category relates to the expectations and needs SUs have regarding interactions with clinicians and is called '*Building blocks for TRs*'.

SUs described two aspects characteristic of helpful interactions: the manner in which clinicians conducted themselves; and the treatment MHS provided.

The interactional aspects of the relationship became a sub-category called '*Being known as an individual*'. The treatment aspects were another sub-category called '*Clinicians doing their job*'.

8.2.1. Being known as an individual

'*Being known as an individual*' is SUs having the chance to talk about their experiences and for these to be heard by clinicians. The key interactional factors included: being listened to; being understood; being treated like an individual; having support and encouragement; being cared about. Having the opportunity to talk about their experiences was cathartic for SUs but also helped to reassure them that clinicians knew about them and were supporting them. For example,

"Well my current CPN he's, he's astounding, he's really... compassionate and supportive, he'll listen to me even when I'm ranting on and raving and just... having a bit of an episode."

(Male, Lancashire Focus Group 1)

'Being listened to' was fundamental to SUs feeling like the clinician was supporting them. Furthermore, being listened to helped SUs feel that clinicians saw them as an individual and a person. A common worry of SUs was that they were primarily seen as a diagnosis and only secondly seen as an individual with experiences outside of mental illness; resulting in a loss of identity that was deeply unsatisfactory to most SUs. For example,

"... they're so negative you know. There's so much written down that's negative. They always like look for the negative. The whole mental health system always looks for negative in people. It's like I'm not really that negative really, I've got a lot of talent and... there's nothing written down about [that...] A few years ago I would have liked to have continued my college and stuff, but they never you know... all they did was put more medication."

(Male, Lancashire Focus Group 1)

"And er, it's the same sort of questions all the time really. I mean they're talking to us, what else have they got to say? They're hardly

going to talk to us about politics or whatever are they? Or music or whatever, so... sometimes I'd rather they'd not talk about things, sometimes I sort of well, they're so obsessed with mental health, why can't they talk about other things besides that?"

(Male, London Focus Group 1)

Many SUs questioned the recommendations or comments of clinicians if they felt that the clinician did not know them fully. For example,

"Sometimes I'm sure it's just labelling somebody, so they can put them in the cupboard instead of, really really understanding them and getting the gist of it. Cos when she said I had bipolar, I only said a couple of symptoms yeah and she was on it like that. Now that was the first time she met me as well, do you know what I mean? I thought to myself, the woman don't even know me, how can she say that I've got bipolar when she don't even know me, just because I've gone in there with a couple of symptoms, and I was coming off 110ml methadone do you know what I mean?"

(Male, Birmingham, Individual Interview)

Being listened to and having the opportunity to talk about things other than illness, reinforced aspects of SUs' wider experiences and unique skills or knowledge. In this way, *'Being known as an individual'* elevated the SU beyond a number or a diagnosis, to someone with 'status'.

The measure of whether SUs felt listened to appeared to differ depending on whether the clinician was a psychiatrist or a nurse/CC. There was an expectation that CCs would take the time to listen to them, and support and validate their concerns. However, determination of whether the psychiatrist was listening, related to whether the psychiatrist understood their goals or agreed with the SU's suggestions for treatment, such as medication changes. For example,

"He listens to me about my medication. Because I was worried about my lithium, [...] and I asked the [previous] doctor to reduce it and he said no, but I said to my new doctor I wanted to give it up, [...] and

he listened to me. So I feel more in control now than I did in the past."

(Female, London Focus Group 2)

SUs described feeling that psychiatrists rarely listened to them as they found it very difficult to get the psychiatrist to agree with suggestions they made for changing their treatment (see Section 8.4). Another way in which SUs assessed whether clinicians were really listening to them was whether their concerns were 'taken seriously'. 'Have a pill and go away' was a phrase used by one SU to describe treatment by psychiatrists that did not adequately address her concerns. For example,

A1 *I feel like that often [A2], I feel like that often. That nobody's listening, nobody cares.*

A2 *I don't think anyone's listening.*

A1 *No nobody cares. It's horrible, yet I chat to people on Facebook in America and there's all sorts of things in place, and...you know from chatting to them, and I say I'm this, I feel suicidal, and they say well go and see your therapist. I say what therapist? [...] For my diagnosis I feel its Britain. If you've got depression then they can give you a tablet and send you away.*

(Interaction between 2 females, Birmingham Focus Group 1)

"...I'd gone out to tell them I was ill that time. And even though I'd gone to tell them the A&E at the hospital they didn't pick up on it. So really I had made my effort to say I was unwell but they didn't respond. They just sent me home with a few sleeping tablets."

(Female, London Focus Group 1)

SUs, mostly, agreed with the need for medication. However, as these quotes indicate, feeling validated and known requires more attention from clinicians than suggesting medication. Indeed, the focus on medication was deeply frustrating for SUs as they saw it as reducing them to an illness, rather than an individual with a wider experience.

8.2.2. Interaction of 'Being known as an individual' with Joint Crisis Plans: 'Being heard'.

The JCP was an opportunity for clinicians to listen, to validate or support SUs. '*Being heard*' indicated to SUs that their concerns were valid and worthwhile. By taking the time to get to know SUs beyond labels and symptoms, clinicians demonstrated that the SU was worthwhile – this is referred to as '*Having status*' and is described in 8.3. For example,

"... CRIMSON listened to [my concerns]. And they asked you the questions you know, what help what support or help would you like if that happened? And I found when I was accepted, and I found it really good."

(Male, London Focus Group 2)

"Well me personally, I actually feel like a human being now. Because I know that if I get poorly for any reason that first, everybody will help me in my own environment, in my own home."

(Female, Lancashire Focus Group 1)

"Well they listened for longer, and seemed to understand a bit better. [I] got a better reaction. And that's it really. I got a better response. Maybe because it's what I wanted to hear I don't know. But maybe the way I interpreted it I don't know. But I seemed to get a better response with the plan and then seeing my doctor and that lady it all seemed to be a lot better, in my eye."

(Male, Lancashire Focus Group 1)

'*Being heard*' by clinicians in the JCP meetings appeared to be linked to improved trust in that SUs believed that treatment wishes they put on their JCP had been agreed to and would therefore be implemented.

However, for most SUs, the meetings did not seem any different from other routine clinical meetings and, perhaps for this reason, the JCP meetings were not remembered by many SUs. Additionally, SUs described situations where clinicians did not engage with the process either through not

attending the meetings or not allowing sufficient time for the discussion.

For example,

"[The JCP Facilitator] *had made an appointment and turned up and* [the psychiatrist] *refused to let her in to my meeting, he said 'it's not on his time' he said.*"

(Female, Birmingham Focus Group 1)

Similarly, a few SUs felt that the JCP Facilitator didn't adequately influence the meeting and therefore their views were not listened to. For example,

A *She seemed very quiet in the meeting. [...] She came to the CPA [and] seemed quite quiet. I had to sort of bring her in and say what does she think about so and so, and what does she think about the plan and stuff like that.*

R *Okay so you didn't feel like she was making an impact?*

A *Not really no.*

R *And how did you feel in that meeting?*

A *I just felt that I wasn't being heard really.*

(Male, London, Individual Interview)

In such scenarios, the experience and benefits of '*Being heard*' were undermined by a lack of clinician engagement or the Facilitator not sufficiently influencing the process. Such implementation problems undermined the 'effect' of the intervention in validating and elevating the SU's status (see Section 13.4 for further discussion).

Many of the key aspects of good relationships from the perspective of SUs were inter-personal, particularly in terms of '*Being known*' and '*Being heard*'. However, interpersonal components were insufficient to establish a good relationship; SUs also required clinicians to be 'professional' in terms of having expertise and providing a service.

8.2.3. Clinicians doing their job

The third sub-category of *'The building blocks for TRs'* was *'Clinicians doing their job'*. This sub-category had three components *'Being reliable and consistent'*, *'Having expertise'* and *'Having boundaries'*.

8.2.3.1. *Being reliable and consistent*

Some SUs reported a lack of reliable and consistent help or access to mental health care. This was described as clinicians not doing their job properly. Most SUs believed that they needed help and monitoring to keep them well and expected MHS to be able to provide help and advice when needed. However, nearly all SUs described situations where they had felt let down by clinicians. Often SUs described being turned away or dismissed at the point of crisis, which in turn undermined future attempts at help seeking and resulted in SUs *'giving up'*.

"And all it takes is for err... these clinicians to have a bit of common sense and a bit of compassion. And say well look really all I need to do is just treat this person, number one with a bit of respect and dignity and empower them. And the best way to empower them is to find out what their problems are and treat them properly. But they don't do that. So it exacerbates your problems. You know I phoned duty they don't want to know. I phoned [area] psychiatric liaison services [...] and the woman said to me before I even stopped what I was saying, look if it isn't urgent can you just ring your psychiatrist tomorrow morning please. And I'm thinking, I was just about to tell her that I was suicidal."

(Female, London Focus Group 2)

Similarly, many SUs described not being able to trust clinicians. Several SUs described experiences of clinicians promising or saying one thing and then doing the opposite. For example,

"Only because once time I got sectioned under the Mental Health Act, Section 3 for treatment, because I stopped taking the medication. [...] They said if you don't take your medication we're going to have to section you. My mum was alive then and I decided to take my medication, and then they come back and they still sectioned me."

(Male, London Focus Group 2)

Similarly the interaction below describes an experience of clinicians saying one thing and then doing another, and the feeling that choices presented to SUs were not 'real' choices, but rather the clinicians pretending to give them choice but having the ultimate power.

A1 *I've needed them once before and actually I asked them to come to the house and like my CPN does and they said no. So as soon as you go to see them in hospital then it's oh, stay a couple of nights in hospital. You're there six weeks. They take a huge chunk of your life away. So I'd rather they, even though I was ranting and raving and it was understandable why they wouldn't come round, cos I was on a real rant. But at the same time I'd rather they came to my house than I have to go to them. Cos then you're on their pitch yeah and they're in control rather than you being in control.*

A2 *When you go in hospital, you're not assessed as soon as you go in, are you? And you can be sat there for hours, and they come up with papers and you can't go home.*

A1 *If you come in you can be a voluntary patient but if you leave we'll section you. So that's a catch 22, you can't win[...] Yeah they are, do what you're told or else.*

A2 *Like to me it's a game of manipulation.*

A1 *Oh yeah.*

R *So it's not a real choice for you is it?*

A1 *No no choice.*

A3 *You don't have any choice.*

A2 *you do [but] you have your liberty taken off you...*

(Interaction in Lancashire Focus Group 1)

In these examples, clinicians may have perceived a clinical imperative to act in the manner in which they did. However, such inconsistent words and actions led many SUs to believe that they were unable to trust clinicians to honour their verbal commitments.

Continuity of care was a further aspect of consistency. Most SUs had experienced clinicians leaving, often without being informed of this before the clinician left. For example,

"Well the thing I don't like about the doctors is that they always keep changing. They're never there for maybe a year, just six months and they go. You're just getting to know them and they just go and that use to be so much with that practice. Cos I've been with them since I was diagnosed in 1995 and up till 2007 they just kept changing them, my care coordinator, you only just get to know somebody for six months and they change them. So that is the only thing I don't like. But now she's the care coordinator, is saying that she feels that she's going to stay a lot longer, but the doctors are not staying for long. Consultants, and the doctors are not staying for long they just stay for about six months and then they're off."

(Female, London Focus Group 1)

SUs described taking time to get to know a new professional, building trust with them and then having to start the process again with a new professional. The effect of this and other aspects of clinicians not 'doing their job' was for many SUs to feel let down and unimportant.

Conversely, where clinicians honoured their commitments or agreements, and met SUs' needs, SUs felt supported, encouraged and trusting of the clinicians. This appeared to aid future help-seeking and a sense of control over their life and experiences.

8.2.3.2. Having expertise

A further sub-category of '*Clinicians doing their job*' was the extent to which SUs perceived that clinicians had expertise. SUs supported by support workers and, in some cases, social workers, sometimes perceived these clinicians as lacking the required expertise. For example,

"This male one is a social worker, social worker has not studied mental this thing, so how can they put me to such a... under him, to take care of me. So when it's time for injection he will go and call a colleague, a female to give me the injection."

(Female, London Pilot Focus Group)

"And when I go out it's with the [support time and recovery worker] takes me out for coffee once a week. And we discuss everything but not really to do with the psychiatric things. We talk about everything and you know, all sorts of things but not really about psychiatric things because she's not really trained as a nurse."

(Female, London Pilot Focus Group)

Similarly, SUs believed that clinicians should know how to interact with them, to have suggestions regarding how to tackle their problems and be able to hear or sit with the SU when they were unwell, for example,

"But the other one it was just a personality clash really we didn't get on you know. And err... and I was very upset once when I was in hospital and she actually rang me on the patients' phone, and err... she ended up putting the phone down on me. And I thought that was really bad. I mean you don't do that to people you know. She said if you don't, if you don't be quiet I'm going to put the phone down. Well I couldn't help being erm, you know my speech was very rapid and I was coming, all ideas were pouring out you know and I was coming out with one thing after the other, and she should have understood that you know, that I couldn't help being slightly motor mouth."

(Female, Birmingham, Individual Interview)

Conversely, with the exception of treatments with negative effects (e.g., wrong/high dose medication; long hospitalisations), SUs did not question the expertise of psychiatrists. As one SU put it 'doctor knows best'. In this way, the input from psychiatrists was important to SUs as they perceived psychiatrists as having particularly useful knowledge and experience.

When SUs believed that clinicians had mental health expertise, they trusted and approached them. However, in situations of a perceived lack of expertise, SUs responded by disengaging or in some cases using outside supports. In this way, the perception of '*Having expertise*' was vital in

encouraging therapeutic interactions with SUs and was a key determinant of whether SUs believed clinicians were *'doing their job'*.

8.2.3.3. *Having boundaries*

One of the aspects of contention in the literature (and as described in the CIS Section 4.3.2.1) is the extent to which boundaries can be maintained in community mental health care, particularly when the frequency of interaction is high and often conducted in the home. Usually the concern is that SUs will expect too much from clinicians. However, the majority SUs in this study had a clear understanding regarding what is 'professional' and what is 'personal'. Rather, SUs described clinicians not understanding boundary issues. A few SUs expressed dissatisfaction with clinicians becoming comfortable and personal, and therefore not meeting their needs. For example,

"I've had a few psychiatric nurses. But it always gets to the stage where, because you become that familiar with that person that you know, they'll have a good old chat about their own life or something that's happened. Because they get that comfortable. And it's like I said, I feel like I'm starting to get in to what I want to talk about, and she'll sit there and she'll go that is all the time we've got... so I feel I'm on a time limit [...] So you know, I'm feeling, well I can't go any further, because to go any further I've got to have more conversation. And she's looking at the clock".

(Female, Birmingham, Individual Interview)

Similarly, other SUs described clinicians who they considered had overstepped the professional line by joking with them in an inappropriate manner. For example,

- A1 *Okay, it seems that he teases me about my mental illnesses.*
- A2 *It's not professional for him to be teasing in the first place.*
- A3 *No and some of them can have a...*
- A4 *I know, I've had that in the past.*
- A3 *I've met them as well.*

(Interaction, Lancashire Focus Group 1)

SUs understood that in order for clinicians to be able help them at points of crisis or relapse, they needed to remain professional. For example,

A *She's still got that professional side actually towards me, as I'm her client, it's actually good that she doesn't see me as a friend I think.*

R *Why is it good?*

A *In case I could get ill again, she's got to stay strong and that and not get too upset and that. Cos a friend would get upset wouldn't they, she's got to stay strong for me.*

(Female, Birmingham, Individual Interview)

In this context, SUs clearly understood the line between the professional and the personal. SUs expected clinicians to be able to help them with their illness and believed that behaving in a too familiar manner jeopardised this help. SUs wanted to be emotionally connected sufficiently to 'get along' but not be 'friends'. However, purely 'professional' interacting was also unsatisfactory (as described above in '*Being known as an individual*'). The ideal state was a mixture of both types of interactions.

8.2.4. Interaction of 'clinicians doing their job' with Joint Crisis Plans: 'Holding clinicians to account'

Many SUs described interactions with clinicians as unreliable and inconsistent. In addition, there was a perception that as the interactions with clinicians were conducted 'behind closed doors', where clinicians were able to do what they wanted and SUs had little influence, that is, a 'closed system'. The JCP was therefore valued by many SUs as they felt that having an external person/organisation present during those sessions was '*Holding clinicians to account*'. SUs described a need for '*Holding clinicians to account*' in two spheres: firstly, the actual interactions/meetings where treatment decisions were made; and secondly, in honouring commitments or treatment decisions in crisis situations.

SUs felt they lacked the power to influence decisions and a few SUs strongly believed that clinicians needed monitoring by someone external to ensure they kept the SU's views in mind (something which CCs described

themselves – see 9.1.2). Feeling unable to influence clinicians, many SUs hoped that the JCP and the Facilitator would address the power imbalance. Similarly, in ensuring clinicians honoured commitments and that plans were reasonable, SUs described the JCP as a 'red card', 'referee' and 'safety net'. For example,

"Because a lot of us are very angry with our psychiatrists because we've not been listened to, and there's no one there to referee and they've got all the power. [...] But I've grown now, I've had my counselling so I can actually say no. But it's inequality of power and if there's somebody else with equal power or higher power than the SU seems to have, in the equation you feel as though you've got a bit more power. So you're more likely to be listened to."

(Female, London Focus Group 3)

SUs hoped that the JCP would be honoured by clinicians as it had been overtly agreed and recorded. SUs described feeling happy and secure with the detailed plan recorded in 'Black and White' which gave it an authority and legitimacy. However, the lack of consistency or honouring of agreements in regular care was also experienced in relation to the contents of the JCP. For example,

"I must admit I had similar views, I actually wanted to have a joint planning, a crisis plan. Because previously what I'd actually requested and what I'd be promised never came to fruition, or very rarely came to fruition. So I thought if it was actually written down in something that we both agreed with, that we both worked towards those aims, of actually getting me the help when I needed it, rather than getting it getting to such a bad crises that I was detained, that if I got help when I said I needed the help, that things wouldn't get so bad again. But all that actually happened by having the JCP and things still not going to plan, and actually getting worse, because every time I tried to say well this is what was agreed, it's... well we haven't got the resources we think you should be in the personality disorder service. We can't help you."

(Female, London Focus Group 3)

There were many experiences of the plans not being honoured by clinicians. In these cases, the hope they felt regarding increased control was not fulfilled. Lack of continuity in clinicians was one reason a few SUs presented for this:

"I think a lot of it's to do with having the same doctor and the same care coordinator, which is like obviously I haven't, I don't think my current care coordinator realises I've made a JCP."

(Female, London Focus Group 2)

One woman described how her CC did not attend her JCP meetings and her psychiatrist left her post the week after the JCP meeting without telling her. This woman interpreted this as a lack of commitment to the JCP and its contents – so she did not trust that it would be honoured. Similarly, all SUs who had been sectioned during the follow-up period did not remember the JCP themselves at the point of crisis, and did not recall their clinicians raising the JCP at any stage in the process.

Conversely, those individuals whose plans were honoured by clinicians felt respected and supported by clinicians. One woman described being hospitalised, but knowing that clinicians had, as agreed on her JCP, made every effort to treat her at home for as long as possible. Similarly, another woman was taken to a general hospital after passing out in the street; her JCP was found in her pockets and the hospital clinicians followed her wishes including particular medications and practical arrangements for her home,

A *Yeah it actually says err...practical help in crises, admit to hospital please contact the person below and ask them if they'll carry out the following tasks for you. Which is a friend. Check my home, doors, cooker and fire's turned off, look after my pet. [...] people have agreed to have these copies myself and two other people, and obviously the GP's got it as well.*

R *So all that was followed when you went to hospital? Yep.*

A *Mm. All taken care of.*

(Female, Birmingham, Individual Interview)

In summary, the experience of '*Holding clinicians to account*' with the JCP was mixed. For many the meeting where the JCP was developed, and the idea of the JCP itself, was a positive experience. Many SUs reported not using their JCP because they didn't think they needed it (which is consistent with data collected on use - see Section 7.2.6). In these cases, the positive impressions of the JCP from the meeting appear to be maintained. However, for those SUs whose plans were not honoured, any positive impressions or hopes that the JCP would improve their care were not fulfilled, and in fact, for a few SUs this experience reinforced their view of interactions with clinicians as a 'closed system' and that clinicians cannot be trusted to 'do their job'.

8.3. Having status – understanding my place in the system

The third major category from the SU data was '*Having status*' which refers to the extent to which SUs felt they were considered individuals with capacity for agency. '*Having status*' captures aspects of: 'agency' or capacity for action; an understanding of one's place within a social structure; and an appraisal by others and resulting experiences within the social structure.

8.3.1. Feeling disrespected by others

'*Feeling disrespected by others*' is the first sub-category of '*Having status*'. Behavioural displays of respect or disrespect appeared to determine how SUs interpreted their status or place in the system. Respect or disrespect could occur in the general community or within MHS. For example,

"Everyone takes the micky out of people with mental health problems, every one does. And it's not going to change, and it's been like that since the year dot. That's why people with mental health problems feel like, I'm sure that it exacerbates their condition, because they feel like they're nothing. They're non descript."
(Female, London Focus Group 3)

"Some of them [clinicians] are bad and some of them are not. I know it's wrong to actually say this, but it's maybe someone should voice it. You'll go in and some of them treat you like you're garbage because

you have got this illness. [...] They think we're thick, we're not human beings. We have got illnesses, but we're not garbage and we do understand we're poorly"

(Female, Lancashire Focus Group 1)

Many SUs appeared to interpret these negative experiences as evidence of their low status. Conversely, displays of respect such as '*Being known as an individual*' and '*Being heard*' (Section 8.2), were interpreted by SUs as evidence that they were worthy of respect and able to influence their own outcome. For example,

R *How do you know that they trust you?*

A *Cos actually when they speak to me like a sane person. Cos before I wasn't, I was like...*

R *Okay, how would you talk to a sane person versus a non sane person, what's the difference?*

A *They don't talk to me like I'm a little child.*

(Female, Birmingham, individual interview)

SUs who lacked in status described not feeling entitled to respect and were unconfident of their ability to affect change, to behave appropriately or logically.

8.3.2. Distrusting myself.

In terms of agency and capacity for action, there were two main groups: some SUs acted to help themselves either through self-help techniques or involving other supports including outside of or within the MHS, or advocacy; other SUs felt unable/not entitled to act or frustrated by frequent failed attempts to act. The determinant of these two groups appeared to be the extent to which SUs had internalised past negative experiences as evidence that their views and thoughts were untrustworthy. '*Distrusting myself*' was therefore the second sub-category of '*Having status*'.

For many SUs delusional experiences in the past meant that they regularly doubted their own perspective. Additionally, routine questions from clinicians may reinforce this doubt. For example,

"Yeah I think I had some sensible ideas over a long period of time but I'm just gradually bringing them together and, and again I'm happy to, I have to ask myself whilst I'm doing it, are any of these ideas delusional, are they psychotic? Actually to be honest once people start talking to you about delusions and psychosis and lack of insight you don't half begin to doubt yourself. So yeah I think I'm probably okay but I'm having to, I don't know... regain my trust I suppose in my own thinking."

(Male, Birmingham, Individual Interview).

From such past experiences, many SUs believed that they could not look after themselves and that they needed clinicians to monitor them. For example,

"I just worry that I'm not recognising my crises and I don't know if I... I'm being watched."

(Female, Birmingham Focus Group 1)

"Male 1 Well sometimes you don't know that you're becoming unwell.

Male 2 I agree.

Male 1 They have to pull you in before you harm yourself or others...

Male 2 Okay."

(Interaction in London Focus Group 3)

For the SUs in this study, '*Distrusting myself*' appeared to be both a consequence of illness, and subsequent experiences of feeling disrespected because of their illness.

8.3.3. Interaction of 'Having status' with Joint Crisis Plans: 'Modelling acceptance'

For SUs who remembered the JCP meetings, a few described how they felt respected during the meeting. By allowing the SU to 'have the floor', listening to their concerns and accepting the SU's suggestions for future

treatment, clinicians demonstrated respect for the SU. Therefore, 'Modelling acceptance' is the third sub-category of 'Having status'. One SU described his experience as follows:

"You know you wanna create some trust or maybe you wanna feel like you know they, somebody's saying a good thing about you. And I think that meeting was for that reason, listening to the conversation and actually telling them things like being part of the conversation. But, at the same time, my head knows and records on that moment, that everybody was, you know, kind of talking nice about me. [...] I mean if you get out of a place and you feel hundred percent better, it's because you know you actually used that time for something that was causing problems in your head."

(Male, London, Individual Interview)

'Modelling acceptance' increased some SUs' sense of status and agency.

For example,

"It's like made me think like if I do get ill I can speak up more. Say what I want, yeah rather than thinking oh yeah just let it happen. Do you know what I mean?"

(Female, Manchester, Individual Interview)

"It was probably quite a healthy exercise in terms of reminding me that I was entitled to a degree of control, if that makes sense?"

(Male, Birmingham, Individual Interview)

However, a lack of engagement by clinicians in JCP meetings and a lack of implementation of the JCPs in practice (see 8.2.4), appeared to undermine any gains in status, with some SUs describing feeling 'duped'.

8.4. Being in control of my experience

The fourth major category in the SU data was 'Being in control of my experience' and can be defined as the perception of an ability to determine one's own experience. Themes of control were fundamental to both SUs' experience of the MHS and interest in and hopes for the JCP. Having high

status appeared to be a strong determinant of a sense of control. Those with internalised views of themselves as having lesser status, had a limited sense of control and believed their experience was mostly determined by others. A subcategory of '*Being in control of my experience*' was '*Influencing change.*'

8.4.1. Influencing change

Most SUs described attempts at influencing changes in their treatment and described the frustration and behavioural results of their failed attempts. For example,

"I sort of felt to myself now that you know, well what can I do about it, I can't really change my team. I can't really change their decision, they're qualified. They've got err, they know what they're doing, so they must have put me in there for a reason. I must have been behaving a little bit odd, maybe a big high or whatever. So it's their decision I can't really do much about it to be honest."

(Male, London Focus Group 1)

In the following exchange from the Lancashire Group, it is clear that a lack of control is a common perception amongst SUs. SUs described how clinicians ultimately made the final decision, so there was no point in trying to influence change.

A1 *Yeah, no. Mm... and when they were there they made their own decisions anyway, I didn't agree with the decisions they made anyway, that was taken out of my hands, so I didn't really want to play the game.*

A2 *You just use to give up didn't you?*

A1 *Yeah.*

A2 *Just sit in the corner and give up.*

A1 *Yeah.*

A2 *Leave it to them. No voice.*

A1 *No not really. If you said anything, I don't know...*

A2 *We'll see, we're the experts...just keep taking your medication, do what you're told.*

A1 *It will get better but it never did so...*

(Interaction, Lancashire Focus Group 1).

An inability to influence change was linked with a perception that clinicians were not really listening to them, for example, if the psychiatrist was really listening, they couldn't continue to advocate the same treatment. An inability to influence was linked with a loss of status, for example, SUs interpreted this as clinicians not respecting their concerns and experiences.

SUs described differing levels of involvement in decisions. Most SU described some level of involvement, but in the majority of cases described being informed about choices, rather than involved in decisions. For example, one woman characterised her involvement in decisions as,

"We'll see, we're the experts... just keep taking your medication, do what you're told."

(Female, Lancashire Focus Group 1)

In response to the perceived lack of influence, SUs described a range of strategies used to influence change, including using others with sufficient status such as tribunals or advocacy groups. In making complaints or using tribunals, SUs described obtaining their desired outcome, but felt that this was only temporary as clinicians reverted to unsatisfactory behaviours once the 'spotlight' moved. In this way, despite asserting themselves and getting what they needed, they felt that services retained ultimate control.

Another method of influencing change was 'playing the game'.

8.4.1.1. Playing the game

SUs described '*Playing the game*' by only appearing to comply with treatment decisions. SUs described showing the clinicians what they perceived the clinicians wanted to see. For example, in the interaction below, SUs described two ways in which they 'played the game': one SU described 'acting down' or pretending to be well to get out of hospital; another describes 'going along with' treatment they don't want in order to avoid potentially more intense treatment.

- A1 *I was 12 months in [hospital] I... erm... and because the tablets made me anxious, they never thought it was the tablets making me anxious.*
- A2 *Mm, they thought it was you.*
- A1 *They thought it was me, so they'd keep me in. Faculties were all there so I was able to get dressed up, put a hat on and say oh I feel 100% now and they let me out and I had to do that then when I came home, I came off the tablets, the course, in the end. But I actually had to pretend to be well to get out.*
- A2 *Yeah.*
- [...].
- A3 *You've to play the game haven't you. Toe the line.*
- A4 *You have to do what they want you to do.*
- A3 *Yeah, and behave yourself.*
- R *There's lots of laws about playing the game, what do you mean about that?*
- A4 *Well you go in, like I say, they give you more drugs than you really need initially. You're drugged up to the eyeballs initially and then they sort of wean you off it slowly. So you get worse before you get better. Erm, but if you don't, if you refuse medication, oh there's a holy uproar, you get it anyway. You've no option so you play along with it, and just go along with it.*

(Interaction, Lancashire Focus Group 1)

In summary, using the strategies outlined above, SUs were able to take some control of their situation. However, in general, SUs were dissatisfied with having to use such strategies as they came at the expense of open, equal and transparent interactions with clinicians and as such, represented a failure to build a TR.

8.4.2. Exceptions to wanting choice and influence

While most SUs in the study expressed a desire to be involved in decision making, there were some exceptions. For a minority of SUs, having clinicians seek their views and opinions on treatment decisions was unsettling as it was interpreted as both the clinician lacking expertise and

an abdication of their responsibility to help the SU. SUs in this category tended to be older or have had many years in contact with MHS.

Another exception involved SUs who accepted that there would be times where they lacked capacity to make decisions for themselves and needed others to act on their behalf. For example, one woman voluntarily accepted a Community Treatment Order (CTO) because she believed that she would get the help required faster.

8.4.3. Interaction of 'Being in control of my experience' with Joint Crisis Plans: 'Ensuring reasonable treatment'

For many, past negative experiences were characterised as situations where they lacked control. By contrast, the JCP provided an opportunity to raise concerns about the past and to contribute to future treatment decisions, thus ensuring reasonable and proportionate treatment. '*Ensuring reasonable treatment*' is the second sub-category of '*Being in control of my experience*'. For example,

"If they read that care plan, they'll know what you want to happen to you and what you don't want to happen to you... So when it's wrote there that I don't want ECT or I don't want this or that, it's given the information that I've gone through, explaining to them, because I can't because I'm in no fit state. You haven't got the time to look at your notes and go all through your history for 30 years and find out what went wrong, and what were good for you and what were bad for you, so if it's wrote in front of them before you go in, they must read it to find out what your stipulations are. Cos obviously then you've got reasons."

(Male, Lancashire Focus Group 1)

The JCP intervention was perceived as a form of influence both in the planning meeting and the final plan itself. In terms of the planning meeting, it was helpful to have someone 'external', to increase transparency of the interactions between SUs and their clinical team. The JCP Facilitator ensured that the SU was heard and had control over the

content of their JCP. When the meeting went well, a few SUs described the clinicians as being 'more reasonable' than usual. For example,

"Well it was just like, they didn't say no we can't do that, they said we'd try and do... they were very helpful, they were saying that at a very last resort you will go in to hospital at the very last resort. Where as before my doctor would say to me, well if your sister thinks you're going to go in to hospital, we'll put you in."

(Female, Birmingham Focus Group 1)

Many hoped the contents of the JCP would ensure reasonable treatment in a crisis. One man described it as a 'red card'

"I joined the JCP because I thought it appeared that there would be more policing involved in the system of it. Where that err, where as instead of err... someone you don't know effectively telling me things, [...] they sort of force you out don't they, they escort you out and they bring the police and you have to go with them. With the crisis plan [...] it is more of a look stop what you're doing send someone to look after these people, namely me in my home. If there's a need to, in an emergency, being a crisis. So I thought it was a good idea because of that. [...] So as far as I see it, if anything was to happen, I would hope that card, [...] that crisis plan as a red card and say look this is what we've agreed and that."

(Male, London Focus Group 3)

For those who had not used the JCP during the follow-up period, this perception of influence from the meeting and the JCP itself was maintained. However, if the meeting did not go well, and/or their plan was not implemented, SUs described distrusting the intervention. In this latter case, some SUs felt the lack of legal enforceability of the JCP (see 5.4.6.2) undermined its influence and according to one woman in London, the JCP was 'not worth the paper it is written on'.

In summary, the ability to influence one's own treatment appeared to be fundamental to SUs' experiences. An inability to influence and ensure reasonable treatment generated and/or reinforced the perception that a SU

lacked status. In this context many SUs described acting in a non-transparent manner, giving up or using others to influence on their behalf - all of which could be seen as a breakdown in the TR. Conversely, allowing involvement and influence in treatment decisions seemed to facilitate trust and good communication between clinicians and SUs. The JCP intervention succeeded, for some, in providing and promoting influence over their care; however, when the plans were not honoured, this was undermined.

8.5. Chapter summary

The SUs in this study presented themselves and their interactions with MHS as being influenced by past (often, but not exclusively negative) experiences. Many saw themselves as being acted upon, lacking control to influence their illness and care, and often of being of lesser status than other people in the community. SUs with experiences of being treated badly in MHS used these experiences to define and frame their future interactions.

In contrast, SUs described a good TR as one that supported and involved them and allowed them to determine/influence their own treatment – thus providing them with status and making them feel respected. *'Being known as an individual'* was a key aspect of feeling respected and provided reassurance that clinicians would act in a manner that was specific to their individual circumstances. Like the findings from the CIS, the notion of 'trust' was very present in this data. For example, clinician inconsistency and not *'Being known as an individual'* undermined SU trust in clinicians. Additionally, the experience of mental illness and treatment taught SUs not to trust themselves.

This initial analysis suggests that for SUs the output of good relationships was increased status, which enabled agency and in particular being involved and being able to influence decisions. Conversely when SUs were not treated with respect or able to influence their care, they felt that they lacked status and the relationship was weakened.

Each of these positive interactional aspects were present in the JCP interaction and therefore, the JCP facilitated the perception of status for the SU. However, these processes were sometimes undermined by issues with the implementation of the JCP meetings (i.e., through poor clinician engagement) and the JCPs themselves. Deficits in the implementation reinforced the notion that SUs had no control and were not entitled to determine their own experience, thus undermining the TR.

The JCP intervention was successful in altering some SUs' perceptions of themselves within the services. It provided an opportunity for SUs to command and be shown respect. There was some limited evidence from this analysis that suggests the JCP affected their relationship with individual clinicians (e.g., through improved trust in 'holding clinicians to account'). Additionally, by improving their own sense of worth (status), it may have improved their perception of their place within the system – that is their relationship to the services in general.

In the next chapter, findings of the CC data will be presented.

9. Care coordinator views on Therapeutic Relationships and Joint Crisis Plans

This chapter presents the findings of the Constructivist Grounded Theory analysis of CC focus groups and individual interviews. This chapter details how CCs described and understood their relationships with SUs in community MHS and what impact the JCP had on these relationships.

Like the previous chapter, the presentation of the findings is organised around three major categories. The presentation of each category has two main components. Firstly, each category and its subcategories will be described. Secondly, the aspect of each category that was affected by or interacted with the JCP will be detailed. The three major categories, their subcategories and interaction with the JCP are summarised in Table 9-1. The numbers in Table 9-1 refer to the section in this chapter in which the category is described in detail. For example, the sub-category '*Focussing on SU*' is described in Section 9.1.3.

In this chapter, the findings focus on CC's descriptions of structural barriers to providing the kind of individualised care central to SU's definitions of the TR as described in the preceding chapter.

Table 9-1: Summary of care coordinator categories

CC Categories regarding TR	Interaction with JCP
9.1: Defining my role as a care coordinator 9.1.1: 'Lacking clarity regarding goals' of Mental Health Services 9.1.2: Responsible and accountable	9.1.3: Focusing on SU
9.2: Care planning ambivalence 9.2.1: Barriers to choice in care planning 9.2.2: Care planning - for whose benefit?	9.2.3: Not benefitting me
9.3: Striving for a TR 9.3.1: Building Trust 9.3.2: Ritualised interactions	9.3.3.1: Highlighting the individual 9.3.3.2: Involving other supports

9.1. Defining my role as a care coordinator

CC descriptions of their role were varied but usually contained elements prescribed by the CPA model – that is, assessment, care planning and review. Many CCs viewed the 'coordination' aspect of their role as the key component. However, for some, this represented a de-skilling due to its largely administrative nature, for example,

A There's a tendency to see [the CC role] as very much as an administrative exercise.

R So you see a conflict between the [...] sorts of coordinating activities and referring and making sure the CPAs happen, with your sort of training I suppose as nurses [...]...Is that right?

A Yeah, the one is subsumed by the other. So I think there's a lot to be said for signposting people in terms of the workload and putting them in touch with appropriate services. But equally err,

there's an argument maybe that you don't necessarily need a professional, you don't need a nurse to do that.

(Male, Nurse, Birmingham Focus Group 1)

The ways in which 'coordination' occurred and indeed, the ways in which it was understood, were varied. Some CCs believed their role involves 'sign-posting' and brokering care for SUs (see Section 2.3.4.1) with the ultimate aim of discharge. At the opposite end of the spectrum, other CCs saw themselves as the central person responsible for the care of the SU, for example,

"Your role is everything, well more or less everything really, because some of them have got family out there, but when something happens you're the first point of contact they come to, they trust you, you become part of the family because I had someone who said to me, I said I was concerned about you and I rang your son, and she said why did you ring my son first? I said well he's your next of kin. She said no you are. So [SUs] see you as everything, family, if they don't have anything they will turn up to you. They trust you, they can tell you so much about themselves, because you always there for them. If you don't see them, you ring, you go knocking, you asking neighbours and calling everybody. Because you care and they know you care. [...] They know. And if they call, you will jump."

(Female, Nurse, London Pilot Focus Group)

Being responsive to the needs of SUs was the focus of all CCs. However, the definition of need was influenced by what the CC believed MHS were trying to achieve.

9.1.1. 'Lacking clarity regarding goals' of Mental Health Services

One of the key points of contention in the CC data, and one that was defining in terms of how CC approached and understood the TR, was the uncertainty about what MHS were trying to achieve. '*Lacking clarity regarding goals*' was therefore the first sub-category of '*Defining my role*' (and is consistent with 'synthesising argument' of the CIS – see 4.3.1).

Three main types of goals were described by CCs: maintaining SUs in the community (e.g., long term care involving regular and intensive interactions); promoting independence within MHS (e.g., reducing input to promote SU capacity); working for discharge (e.g., promoting independence from MHS, stabilising SU with medication and discharging). Within these models, CCs described a range of roles that they fulfilled, and at times, indicated both conscious and unconscious contradictions.

Most CCs presented MHS as changing and moving away from maintenance care to working for discharge. For example,

A *We don't, the service the way it's designed now and the way it's going forward isn't that of a service where by, we have the worried well tea and sympathy time. We just don't have that facility anymore.*

R *And that's a change from how it use to be?*

A *Yeah I think so, certainly from about six or seven years ago, people, I had when I was working in home treatment I'd work with CCs, they'd had people on their case loads of years and years and years. Now, the ethic is that we look from the minute they come on to our case load for discharge. We're discharge planning from day one. You know to get someone to stability where they don't need, this CC. Because medics can care coordinate in outpatients and you know if there's no issues they can go back to GPs. I mean we can't, because of the nature of the clients coming through at the moment we can't carry people who have been in services for years.*

(Female, Nurse, Birmingham Individual Interview).

For some CCs working for discharge meant stabilising SUs through medication and not having an opportunity to do more therapeutic work. Other CCs believed that many SUs would always require input due to the complexity of their needs and aimed to promote feasible independence within the services. Conversely, a few CCs felt that past intensive involvement and maintenance approach of services led to some SUs being unnecessarily reliant on them. For example,

"I think the problem you have is people who have been in the services for 20 years already, who come along with a learned expectation and, they're very difficult to change their expectations. Erm, you know and the reality is often people who have been in services for a long time are very dependent".

(Female, Nurse, Birmingham Individual Interview)

In summary, there was a lack of consensus amongst CCs in this study about the goal of MHS, and their role within this system. Those who were working for discharge, focussed on building independence in SUs by decreasing interpersonal contact and responsiveness to requests. Those who believed their role was to support SUs to stay in the community, focussed on providing care, support and encouragement and prioritised responsiveness. There are clear links here with SU data on '*Clinicians doing their job*' (Section 8.2.3) particularly in terms of unreliability and inconsistency (Section 8.2.3.1).

9.1.2. Responsible and accountable

As discussed above, CCs described their primary focus as SU need. How that need was defined was influenced by the CC's understanding of the goal of MHS and their role within that. In addition to the goals described in Section 9.1.1, which could be considered 'internal' to services, there was an additional role described by CCs: a responsibility to 'manage risk' or to ensure the safety of SUs and the wider community. '*Responsible and accountable*' is therefore the second sub-category of '*Defining my role*'. This sub-category adds another layer to CC's conception of their role that originates outside of the one-on-one interactions with SUs.

All CCs mentioned 'risk' as a key concern. Risk was broadly defined,

"There's many risks, there's the risk of deterioration of mental health, there's the risk of aggression, perhaps towards others, perhaps self harm, a risk of using drugs and alcohol. And then perhaps there's the risk of vulnerability, that you could be exploited by other people in various different ways. So there's financial exploitation as well that's another risk that we worry a lot about. We've a lot of risks."

(Male, Nurse, London Focus Group 2)

A minority of CCs were overtly conscious of the role they were required to play within the broader community to ensure risky behaviours of SUs were adequately controlled. These CCs believed the performance of this role undermined developing trusting relationships with SUs,

"...but some of our clients I know they don't trust us, they see us as some form of social control, an element of social control for them, making sure they are getting medication."

(Male, Nurse, London Pilot Focus Group)

"Erm, I think there needs to be a continued use if you like, whatever you call it, authoritarian, or paternalistic kind of structures in mental health service. I'm a social worker by training, so it doesn't necessarily wholly sit easy with my training [...] I do believe there are circumstances rightly where people should be detained and deprived of their liberty under the Mental Health Act. Cos of the risks to themselves by virtue of the mental health or at risk erm, towards other people. [...] We are agents of social control, we need to take responsibility and acknowledge that that's the perspective that the state has, what the state expects from us as well, we should be honest about that."

(Male, Social Worker, Birmingham, Individual Interview).

Likewise, while not overtly discussing their responsibility to the community, the majority of CCs believed that the focus on risk was counter-productive to developing a TR with SUs, and occasionally prevented working with the interests of SUs in mind:

"Sometimes you can't see the wood for the trees and when you're kind of, you know week in week out sort of chasing people around, especially like you know AOT [Assertive Outreach Team...] you kind of lose track of what am I suppose to be doing? For sure you know a lot of it's about risk, and kind of trying to prevent anything sort of like, god forbid terrible happening. You know cos that's the kind of, you know you always look at the worse case scenario. So you're always

looking at risk management, and if something goes wrong and I've not seen this person when I'm supposed to, what's going to happen to me? So we're driven by that. So sometimes that anxiety [...] can sometimes rub off on you know the SU, or they might pick up on you know certain levels of erm... sort of anxiety in us, erm... I don't know. Can be a barrier for [...] the therapeutic sort of like alliance and, I think very often because we're just chasing people all the time, months might go by where we've not actually sat down and really done something productive, and positive, and sort of like meaningful to them in any way."

(Male, Nurse, Lancashire Focus Group)

In the above example, the nurse described how worrying about risk not only prevented him from doing 'productive and positive' work to help the SU, but was also partly self-protective. Many CCs described how aspects of their role performance met their own needs and those of MHS, rather than those of SUs (see Section 9.2.2).

Regulations designed to mitigate risk for professionals may also undermine meeting the needs of SUs. One CC described a situation where a SU rang the crisis line and was agitated. The crisis team refused to visit her due a note on her records describing her as a risk to professionals when agitated:

"...Which is part and parcel of the way crisis works and there's not a problem of that, because you don't want to walk in to dangerous situations. But for this lady it was a case of well, what good are you to me, you know I'm in a crisis and I need help and you're not coming out when I need you so... after that she was adamant she wouldn't ring crisis again [...] Cos I don't think they did wrong the first time, it's just it didn't meet what she expected."

(Male, CPN, Lancashire Focus Group)

As a consequence of this risk management strategy the SU disengaged from services. Many CCs described how wider policy frameworks and accountabilities could sometimes prevent them from practising as they would like, for example:

"But I think it's something that will take time, a lot of change of attitude is needed in getting your clinicians to be more patient centred. Something that's not just going to happen from one day to the next. Many changes in whole of the policy, major policy changes itself, might have to bring about. But at the rate we're doing we are too focussed on those other things to be, to have, to be so patient centred, or to be as patient centred as we want to be, because there are so many other competing priorities, or maybe more important priorities. The policy changes might bring that around."

(Male, Nurse, London Pilot Focus group)

This subcategory links with the SU data on 'The building blocks for TRs' (Section 8.2) as some CCs described not being able to get to know individuals due their wider roles captured in the sub-category 'Responsible and accountable'.

9.1.3. Interaction of 'defining my role' with Joint Crisis Plans: 'focussing on service users'

As described above (and also in the CIS – Chapter 2), the ambiguity regarding the goals of MHS and the role of CCs appeared to reduce the capacity of CCs to focus on SU needs. Many CCs believed that the most important impact of the JCP intervention was the unequivocal focus on SUs, something they felt they were unable to do, either due to time constraints or competing roles. 'Focusing on SUs' is therefore the third sub-category of 'Defining my role'. For example,

"I mean [the JCP Facilitator] had time for the clients. She worked with them at their own pace. She was approachable, she respected them. And that's what they expected and that also happened so much."

(Female, Social Worker, London Pilot Focus Group)

"I can see somebody taking part in a research, it's quite exciting for somebody, this person for example. He'd have been quite excited about taking part in it and looking forward to coming and speaking to

somebody about his side of mental health and what he thought. Somebody was listening to him properly and writing it down and he's also getting money for it as well. I think it would have been good for him self esteem wise you know. I think he probably would have felt listened to and felt quite important people taking his illness quite seriously."

(Male, Occupational Therapist, London Individual Interview)

A I mean we can do it but there are time constraints. But I also do think it worked well because it was an outside person, I think, for me it felt more objective, erm... and I think the client as well that they look at it that way, that it's a bit more objective, it's not me coming with all my knowledge about them, to force...

R Yeah. So it was your concern then if you did it yourself, your history with that person would somehow ...

A ... might prejudice it, yes.

(Female, London Focus Group 3)

In the final example, the independence of the JCP Facilitator is emphasised. Most CCs believed that this was a crucial factor in the success of the JCP for two reasons: firstly, to ensure that the plan was actually completed; and secondly, the impartiality increased SU trust in the process. Both of these scenarios illustrate a fundamental conflict for CCs. The majority expressed a commitment to focus on SU needs and to be 'person-centred', however, they also described understanding that in many ways their role did not enable this.

Conversely, '*Focusing on SUs*' was a source of concern for a minority of CCs who described the potential for encouraging dependency on MHS and/or producing plans that were not clinically useful through uncritical acceptance of SU wishes. For example,

R Yep, so what was your role in those meetings? Did you feel erm... what did you feel was your role?

- A *Erm, a lot of it was... I was involved initially but when it came to drawing up the care plan that was between the facilitator and the service user.*
- R *Ok, so you felt that you weren't involved in the process in the specifics of deciding what was put down?*
- A *Yeah.*
- R *Yeah, ok and what was it like for you that experience?*
- A *I think I was a little bit frustrated really especially with the service user selected as I felt that her requests were unrealistic.*
- R *Ok because you didn't feel involved in that you weren't able to share your knowledge of the likelihood of that.*
- A *No.*

(Female, Nurse, Birmingham, Individual Interview)

This example illustrates possible deficiencies in the implementation of the intervention as clinicians should have been encouraged to discuss the advantages and disadvantages of all SU choices. However, this open discussion was not always achieved, either through a lack of true engagement from CCs or psychiatrists (as described by many SUs), the JCP Facilitator not sufficiently involving CCs (as illustrated above), or CCs choosing not to raise issues. In this context, inadequate involvement of CCs in the meeting appeared to have two effects: firstly, marginalising CCs and therefore not altering the TR, or perhaps damaging it; and secondly, challenging aspects of the CC's role such as accountability, which was perceived by a minority of CCs as interference. However, for some CCs, being marginalised and thus not so heavily relied on by the SU was a positive outcome of the JCP intervention (see Section 9.3.3.2).

9.2. Care planning ambivalence

The second major category identified from the analysis of CC data was '*Care planning ambivalence*' in routine care. One of the key aspects of the CPA and the responsibility of CCs, care planning was routinely criticised by CCs in this study. '*Barriers to choice in care planning*' was the first sub-category of '*Care planning ambivalence*'.

9.2.1. Barriers to choice in care planning

There was a strong commitment to the idea of *joint* care planning amongst CCs, which they defined as SUs being involved and helping to decide the contents of their care plan or treatment. CCs believed that not only do SUs have a right to this involvement, but it also helped to improve the commitment of SUs to the contents of the plan i.e., to ensure compliance. However, when describing the care planning process, many CCs acknowledged that they rarely achieved this ideal. For example,

"I guess you get a bit beaten down, you know the consultant usually turns up to the CPA does a lot of the talking, and prescribes what should happen, and you just get weary with it really and just end up writing really."

(Female, Social Worker, London Pilot Focus Group)

Likewise, when discussing how the contents of the plan were decided, some CCs described identifying a need, making a suggestion, asking for agreement from SUs and then recording this. Directing the flow of information in this way could be considered more consultation than joint planning and is consistent with SUs' reports regarding lacking influence (see 8.4.1). For example,

"And if there is anything that I feel needs to go in, I suggest that, I say what do you think? And then, the other thing that needs to go in is and we go through. That's it - agree. That's it. Make a copy of that report for the SU. But one thing is that they don't, don't look at the report."

(Female, Social Worker, London Focus Group 2)

"I think it's at the tail end of a huge great CPA, it's like the last bit and it's almost, you're not really... you're just sort of saying it as oh that's the same, that's... you're not involving the client really in that. You should be but invariably because you're doing it in a hurry at the end of a review you know, and you want to get it finished, it... it

wasn't the... probably wasn't erm in the client's eyes the most important thing."

(Female, Social Worker, London Focus Group 3)

A minority of CCs questioned whether services are in fact set up to enable SU choice/involvement. For example,

"Yeah I would prefer the responsibility to lie with the SU. [...] it would be better if we were a little bit more flexible where they could sort of tell us what it is that they need and then we could sort of like provide that and they're responsible to kind of you know, engage with that agreed care plan. However it seems that the way our organisations are, we, we still continue to sort of like dictate you know, this is how our service is and this is what is going to happen, alright you might not have seen anyone for 10 years properly however we're going to do a full physical health check list on you [...] and we think that you need x, y and z. You've got to take it otherwise you're not engaging and therefore... how does that make them feel then."

(Male, Lancashire Focus Group)

In addition to such barriers to choice, CCs described situations in which the MHS provide SUs with either no or very limited choice. For example, an Assertive Outreach clinician described his approach in situations where the choice was very limited,

"... there will be certain things that you can give them that choice. But there will be other things and they have no choice and they have to take their medication in front of you but certain things, you can give them the choice, you know. How do you want to take the medication? What time would you like to take it? How would you like it? So you can give them a certain amount of choice, so that can empower sometimes."

(Male, Nurse, London Pilot Focus Group)

"I think to be honest the care plans we had already were more service driven. You know they were a case of, this is a care plan, this is what we do. Yeah we can ask you what your needs are and what

you want to happen, but essentially this is what we do, this is what we can do, and this is what will happen should you ring up."

(Male, Nurse, Lancashire Focus Group 1)

CCs described having concerns about the suitability of some SU choices. For example,

"And also, there are things that SU will want and request and you know it's not really what they need. Erm, and you have to find a way, to actually communicate that, get them to understand without actually hurting them or without actually sending a message that you don't want them to get that, or you don't want to do it."

(Female, London Focus Group 2)

The last example captured a struggle that most CCs alluded to – that is the conflict between choice and beneficence, i.e., that some SUs may make choices that CCs do not believe are in the SU's best interest. This CC described a struggle to maintain an illusion of choice and yet having to reverse that choice.

Conversely, the next example illustrates a different, but in the view of the CC equally problematic, approach to SU choice. The CC described a situation where a SU had agreed to a care plan where he needed to come into the clinic to receive his medication:

"... he just decided one day he didn't care about his care plan anymore. So he phoned up and said I'm not coming for my depot someone's going to have to come out and give it to me. And I was on duty, he's not my client, and I said well no actually that's not what your care plan states. Your care plan states that you come here this week. Can you tell me why you can't come? I just can't be bothered. So you need to come here and give it to [me]. Well no actually we don't need to come there and give it you. If you're choosing not to accept your medication today, I'll document it as that. Is that what you're saying that you're not going to take your medication today? And erm, he got really arsy about the way I put it, totally professionally put it and you know he slammed the phone down on

me and then rang erm, it was [name] one of the senior service managers, and said that I'd refused to give him his medication, blablabla. I said no actually, when they rang me and said, why have you not gone running out to this man? I said look I've got nine sets of notes here on this man, this is him, this is what he does [...] And [my manager] said yes I'm instructing you [to go and give him his medication] and he got his depot and he's never been [to the clinic] since. Disengaged with all his outpatient appointments, cos now he can get a doctor to go to his house and set back the work that his CC had done. Worked really hard got his care plan up and running, he'd signed it and agreed to it. And because he made a complaint we all had to bend over, for want of better words. And it actually set back his recovery in my opinion."

(Female, Nurse, Birmingham Individual Interview)

In this example, the CC believed that the SU's independence and self determination was undermined by their own choice. In contrast to the previous example, the response of the services was to enable the SU's choice. These two examples illustrate the lack of clarity regarding the goal of intervention in MHS and indeed how to define 'best interests'. This analysis suggests that this lack of clarity is often influential in how clinicians interact with SUs and relates strongly to the SU subcategory '*Being in control of my experience*' (Section 8.4) and to the inconsistency as described in Section 8.2.3.1.

In summary, the ideal of joint planning and choice is something to which CCs aspired, however, they described aspects of policy, routine procedures, and concerns about beneficence and responsibility that appeared to be in conflict with enabling choice for SUs.

9.2.2. Care planning - for whose benefit?

Underlying many of the attitudes towards care planning for the CCs in this study was a question regarding the clinical utility of the plans. '*For whose benefit*' is therefore the second subcategory of '*Barriers to care planning.*'

The majority of CCs believed that SUs did not value or use the CPA care plan developed in routine care. Many CCs described situations where SUs deteriorated very quickly, and were thus not capable of recognising, remembering and or complying with the contents of their care plans. However, some CCs described situations outside of an obvious relapse (e.g., agreeing to keep their houses clean) which SUs also did not honour. CCs explained this lack of compliance as the result of SUs not caring about care plans. A few described SUs who had thrown out their CPA care plan or had no knowledge of where it was. For example,

"One of the reasons I'm so sceptical is that I actually do sit down and do care plans with people, but I go back the next week and say oh can we look at that copy of the care plan again, and they can't find it. And you think... you know... am I really kidding myself that doing it jointly actually does make a difference? I mean I don't know that it necessarily does, that's one of my concerns that I can buy in to the notion of joint planning. But when it really comes to... it... it tends to fall short."

(Male, Nurse, Birmingham Focus Group 1)

A1 You can have a huge great list of care plans that you're going to have to kind of give to someone to kind of like flick through. And I 100% believe that people don't look through the care plans.

A2 They don't even know where they are when you ask them.

A1 No they don't.

(Interaction, Lancashire Focus Group)

This was a point of great frustration for CCs as care plans were time consuming to complete and their completion regularly audited. Most CCs explained this lack of engagement or honouring of plans as a result of SU illness. There were no reflections about how aspects of the process may affect the level of engagement of the SU (e.g., see 8.4.1.1 regarding '*playing the game*').

Rather than meeting the needs of SUs, most CCs believed that routine care planning was designed to meet the needs of the MHS. A few CCs said that

the process of documenting the care plan was a measure to protect themselves, rather than seeing any intrinsic benefit in the process or the document for the SU. For example,

"Yeah, it covers me in case anything goes wrong. Even though it's got the clients well being at heart, and it's good for the client but primarily it covers me."

(Female, Nurse, London Focus Group 3)

"You very quickly have to learn about all our documentation that we have to fill in [and] that we're checked. You know we're constantly monitored. You know, is our health and social needs updated, are the care plans updated, is the safety profile in date, has it been reviewed in the last 12 months? If not you're getting a red mark, you're getting an email from the director."

(Male, Nurse, Lancashire Focus Group 1)

"I've asked my clients if they've had any thoughts of harming themselves and they've said no. I've documented it and if something happens, obviously it's bad but, as long as I've documented it as long as I've seen the person, as long as I've done as much to support them without being too intrusive."

(Male, Occupational Therapist, London, Individual Interview)

In summary, most CCs believed care planning was not valued by SUs, was not clinically useful, was required by management and provided medico-legal protection for CCs. Additionally, CCs described uncertainty regarding the benefits of SU choice and how to ensure the SU's best interests were at the centre of decision making.

9.2.3. Interaction of 'Care planning ambivalence' with Joint Crisis Plans: 'Not benefitting me'

The context of ambivalence outlined above and questions about the feasibility of SU choice meant that the JCP intervention was met with considerable scepticism by CCs. Most CCs described initially believing that

it was duplicating work and for some, it involved creating another care plan of questionable value.

Despite such initial impressions, after seeing the finished product, many of the CCs, did see the value in the JCP. (However, it should be noted that by virtue of their attendance at focus groups/interviews such CCs were likely to be a more enthusiastic group than those who did not attend). The key point of difference highlighted by these CCs was the JCP's unequivocal focus on SU views (see Section 9.1.3). Additionally, whereas CCs who didn't acknowledge problems with routine care planning mostly didn't see the difference, CCs who recognised that the ideal of joint planning was not always achieved, also acknowledged that the JCP had the potential to demonstrate respect for SUs in a way that routine care planning did not. For example,

"I do think the crisis plan was good, you know in this formal meeting, she really did get her opportunity to give her views in a formal setting. Which is probably quite empowering actually. It's one thing to chat in her home isn't it? But to go to a meeting where you are really asked about the efficacy of the service, must be quite empowering really."

(Female, Social Worker, London Pilot Focus Group)

These CCs acknowledged that the JCP was potentially quite empowering for SUs, particularly having a consultant psychiatrist present during the discussion. For example,

"Yeah I think they like to think the doctors on board. I mean it's different based on the age of the SU, and also the culture. For instance I think a lot of the black, those of an Asian culture hang on every word from the Asian consultant for instance. So to know that they're on board with it and if they say to them this is a good idea, then they'll follow it and conversely if the doctor says I don't value this I don't see the point of it, I think it undermines it for them as well. It depends on the individual. Some people don't see consultants as useful or important at all do they?"

(Male, Nurse, Lancashire Focus Group)

A1 *It gave the patient a sense of empowerment.*

ALL *Yeah, absolutely.*

A1 *It made them feel important.*

ALL *That's right.*

A2 *In control.*

(Interaction, London Pilot Focus Group)

However, despite the potential benefits for SUs, the majority of CCs did not perceive any clinical benefit for themselves. There were several reasons for this. Firstly, like the experience with the CPA care plan, there were examples where they had tried to implement the JCP at the point of relapse, and the SU didn't acknowledge the JCP. For example,

"But what I thought was the disappointing thing was when this girl did have a, her mental health did break down and her doctor, the consultant and I went round and waved this [JCP] in her face, and said look [SU] this is what you said, you won't be...oh fuck off. Come on [SU name] this is cutting edge psychiatry here, oh get out of my place. So [...] unfortunately it didn't seem to make any difference."

(Female, Social Worker, London Pilot Focus Group)

Secondly, CCs believed that the process and the plan were for SUs. In this context, some never looked at the completed JCP even though a hard copy was sent to them and an electronic copy was uploaded onto patient records. Thirdly, some described situations where SUs may relapse and the CCs themselves would not be involved and therefore not be able to ensure that the JCP was followed. Finally, many described not actively contributing to the meeting because they were not required to by the JCP Facilitator and/or they felt that their contributions would undermine the experience for the SU. For example,

"Well that meeting like I said was a little bit difficult, err... I can't remember if, I think I was just quiet in that meeting, if I can remember. Because it was mainly the consultant and [Facilitator] doing a lot of the talking and the patient just answering."

(Female, Social Worker, Birmingham, Focus Group)

"It was done before wasn't it [...], the plan was done over a period of time, with the facilitator so that it was presented and gone over, at the CPA."

(Female, Nurse, London Focus Group 3)

A *I think this stuff about the broader range of, there's stuff about risk issues, when his mental health deteriorates that, I can't... I'm not in the position to say, definitely should be part of any relapse plan, whether it be by Crimson or otherwise. But be my head, just what I feel I understand about him as a person, what I know from him in terms of erm, what's gone on before. I'd argue we... mental health services, need to be mindful of, that he wouldn't want in the joint crises plan. Erm, so... so that's why, I know when we were actually engaged in the process, I had to debate with myself how far, in terms of my contribution to the process, how far do I push you for things to be involved that... I mean I think should be involved but I know maybe a contentious point for the...*

R *So how did you tackle that?*

A *I guess I tackled that by avoiding [...] bringing them up.*

(Male, Social Worker, Birmingham Individual Interview)

In summary, the JCP was introduced into a context of CCs questioning care planning and the methods through which it is best delivered. As a result, many CCs didn't see the benefit of the JCP over and above existing arrangements. Others did see a benefit for SUs as it was more 'person-centred', however they did not perceive any benefits for themselves in terms of practice or the TR with the SU.

9.3. Striving for a Therapeutic Relationship

The previous two major categories provide a synopsis of the structural issues and broad context within which TRs are conducted in routine care

and in which the JCP was tested. The third major category focuses on CCs' understanding of and processes through which they build a TR and descriptions of interactions with SUs.

For most CCs the measure of a TR was the extent to which SUs wanted to see them and approached them in times of crisis. Engagement and compliance with treatment were therefore key focuses of CCs when discussing TRs (see also Section 4.3.1.1).

9.3.1. Building trust

'*Building trust*' is the first sub-category of '*Striving for a TR*'. CCs emphasised trust as a way of ensuring engagement in treatment. For example,

"But them trusting me - I try to work hard on that. Because with that, that will be helpful in [getting the SU] to cooperate or not only with me but with the service as a whole."

(Female, Social Worker, London Focus Group 2)

CCs described a number of strategies to develop trust including giving SUs a little independence or 'positive risk taking'. For example,

"I think sometimes you have to take risks with people you know, erm... and maybe that's one of the things I thought that was quite good about the [JCP] is that, there maybe something in the crisis plan that would say that they don't particularly want to happen, and... maybe just running with that, and taking that risk with that, sometimes can really help the relationship as well. [...] I've found that taking a few risks has really helped. There was someone who started hearing voices... The previous care coordinator had straight away put in home treatment team and this person didn't like this straight away. So rather than doing that, we decided that we would not refer them to the treatment team but he agreed to phone me every day and that I would visit him twice week on a Monday and a Friday and increase the medication, and then the whole episode blew over without the need for intervention..."

(Female, Nurse, London Focus Group 3)

By demonstrating trust in the SU, the CC hoped that the SU would equally trust them to provide help and assistance in relapse situations, thus promoting help-seeking/engagement.

Another method used by CCs to build trust was by proving their worth to SUs through practical help with housing, bills and/or advocating for them with colleagues. For example,

"Because you do give them time, in our team we have small case loads so we can give time and do things for them, so that they benefit, so their housing, problem with family, so after a while they begin trust you and it becomes easier. Some of them, they're at a different stage in there... they are not ready to trust you I think."

(Male, Nurse, London Pilot Focus Group)

"She sees me like her advocate. Well she's actually a gay woman and she had some very inappropriate sexual behaviour towards her from other people [...] And I did make a complaint to the ward manager, and to the management, but he didn't take it seriously. And I didn't do it to be disloyal to colleagues but I was quite shocked that this was going on in the wards [...] I think she saw that I wouldn't allow things and that I'd be in her corner and now she just calls me all the time, every time something happens."

(Female, Social Worker, London Pilot Group)

'Building trust' was emphasised as a key process in 'Striving for a TR'. CCs recognised that consistency and reliability were important factors in developing trust. However, CCs highlighted a number of barriers such as limiting choice and being 'Responsible and accountable' that hindered the development of trust with SUs. Like the barriers to 'Focusing on SU' described above, CCs perceived this issue as being out of their control.

9.3.2. Ritualised interactions

One of the ways in which CCs described their interactions with SUs indicated a certain amount of repetitiveness. 'Ritualised interactions' was therefore

the second subcategory of 'Striving for a TR'. 'Ritualised interactions' occurred in both the process and content of care planning and routine interactions. This seemed most common when there was some form of risk, such as not taking medication. For example,

"I was going to say that, I think we do sometimes lose sight of the client, I think we, from your study this questionnaire and that it helps us focus on what the client's issues are really. And to sort of work from there, because you know there's reasons why they may disengage, there's reasons why they don't want to take medication. And unless you really listen to those reasons you know, and don't keep bashing them on the head saying you've got to take it you've got to take it, unless you really listen to where they're coming from, [...] you know you just lose sight of what that client really wants to help them, get back on their feet."

(Female, Nurse, London Focus Group 3)

However, repetitive behaviours also occurred when CCs perceived limited clinical benefit, for example, one CC described the crisis and contingency component of the CPA plan as 'barking the mantra'. That is, there is a standard care pathway in a crisis and that is what is entered into CPA care plans. For those who didn't see additional benefits of the JCP approach in terms of detail, one of the criticisms was that 'SUs know what to do.' For example,

"Yeah I mean you have a CPA review every six months, we set certain goals then which are then reflected in the care plan. But yeah again, as [my colleague] said you give them a copy of the care plan, the crisis plan but I don't really think it's taken in by them. Most clients anyway. Most of them are aware, in terms of the crisis plans a lot of them are fairly basic anyway it's just err, contact your CC who may arrange an emergency appointment, and you know to try and see the consultant or the doctor as soon as possible. And then consider home treatment, go to A&E if it's outside hours. You know it's very standard and the clients just... they know most of it anyway. So most of them do anyway."

(Male, Nurse, London Focus Group 2)

Issues about the manner in which services are set up and the implicit directives (and occasionally, contradictions) about choice and responsibility facilitated and created such 'ritualised' relationships. Concerns about choice and/or responsibility did not facilitate an environment where alternatives were easily considered. Rather, standard approaches to situations appeared to limit the opportunity to take a more individualistic approach. As one CC said,

"...what I'm saying is that these very err... sort of entrenched ritualised relationships that we all have that don't actually foster more open debate and looking at what people might do in terms of taking responsibility for their own crises."

(Male, Nurse, Birmingham Focus Group)

9.3.3. Interaction of Striving for a Therapeutic Relationship with Joint Crisis Plans: 'Highlighting the individual' and 'Involving other supports'

The strategies used by CCs to build trust and TRs with SUs were often present in the JCP process, but were not noted by CCs in this study. For example, the JCP could facilitate 'positive risk taking' in allowing patient choice and/or through proving the CC's worth through committing to provide practical help in the event of a relapse. However, the two key components of the JCP which were linked to '*Striving for a TR*' were '*Highlighting the individual*' and '*Involving other supports*'.

9.3.3.1. *Highlighting the individual*

As a result of large workloads, lacking time for direct patient care and '*Ritualised interactions*', some CCs described how the JCP '*Highlighted individuals*'. The JCP meeting and the resultant plan provided detailed information about individual SUs. By using the SU's own wording and by focusing specifically on their identified needs, CCs identified that a benefit of the JCP process and plan was how individuals began to stand out from their large case loads. For example,

"I think what I like about the plan is when you look at it, she kind of stands out, particularly if you've got a big case load... you know not

that faces blur, or cases blur, but she does stand up more as an individual and I think that would be nice for every one of my clients, you know that you can go back and you can look at it, and that person does then jump out at you a lot more, than normal really."

(Female, Nurse, London Focus Group 3)

9.3.3.2. Involving other supports

For some CCs, the process of developing a JCP was a helpful precursor to discharge and decreased the risk of dependency. By interacting with the Facilitator and thinking about their own experiences, the CCs believed the SU was less dependent on them for assistance, for example,

"I think it was really good for the client, because we're encouraging them to you know, take responsibility, encouraging them to, leave the mental health service once they're well enough, but I think that is part of the process is being able to engage with other people and not to be babysat by us really."

(Female, Nurse, London Focus Group 3)

"Well [the JCP] is ventilating [...] it's very closed when it's [...] just the coordinators and sometimes quite isolated clients - it can become quite claustrophobic. I think that having a fresh look into things can ventilate make things a little bit easier for all of us really."

(Female, Nurse, London Focus Group 3)

Both of these quotes give an impression of interactions with SUs as burdensome to CCs. CCs suggested that feeling responsible for SUs' wellbeing and being the main point of contact can be a difficult and effortful task; having other people involved reduced the burden on CCs. CCs saw the Facilitator as acting on their behalf in this small way. The fresh perspective and focussing on the individual's views also helped to prevent the ritualised approach discussed above.

Similarly, the JCP often highlighted other supports outside of the MHS. CCs spoke encouragingly about involving carers and other supports both in the

process of deciding the plan and in active support of SUs in a crisis. The JCP provided a structured interaction through which these arrangements were formalised. Often this was discussed in more 'recovery' based terms, yet many CCs described how involving others had the potential to make their role easier. Despite these benefits, the majority of CCs did not believe that their TR with SUs was affected by the JCP intervention. Rather, for many CCs the important relationship appeared to be between the JCP Facilitator and the SU.

9.4. Chapter Summary

Consistent with the results of the CIS, individual CCs held different views of their role within and the overall goal of MHS. It is possible that the goals are changing and that the lack of consistency in approach amongst CCs is reflective of a system in a state of change. The most dominant view appeared to be that MHS are aiming to promote autonomy and independence in SUs. Yet, in some key ways (such as enabling choices) the policies and procedures of clinicians and the services appeared to undermine this goal. The lack of clearly defined goals and roles for CCs leads to inconsistent approaches between different CCs. This lack of overall clarity created difficulty and uncertainty in interactions both in routine care and the JCP intervention where the aims may have been contrary to some CC's perception of their role.

All CCs in this study described a desire to have a positive impact on SUs lives. They understood what SUs wanted from them in terms of a TR (for example, CC's use of 'person centred' care is analogous with the SU sub-category of '*Being known as an individual*'), however they described many barriers to developing such TRs. These barriers appeared to lead to either inconsistency, or routinised/non-individualised care. The JCP provided a potential avenue to address some of these issues, but CCs mostly did not perceive the benefit for themselves, although, they did acknowledge the benefit for SUs.

There is suggestion of a problem with implementation of the JCP as many CCs reported that they did not feel involved in the process of discussion. This is consistent with SU reports of a lack of clinician involvement and commitment to the JCP process, and suggests that clinician engagement may be fundamental to its effect.

In summary, the JCP did not affect CCs' views or experience of the TR.

10. Psychiatrist views on Therapeutic Relationships and Joint Crisis Plans

This chapter presents the findings from the Constructivist Grounded Theory analysis of the psychiatrist individual interviews. The aim was to investigate how psychiatrists describe and understand their interactions with SUs and the impact of the JCP.

Like the previous two chapters, findings are organised around major categories, and each category has two main components. Firstly, each category and its subcategories will be described. Secondly, the aspect of each category that was affected by or interacted with the JCP will be detailed. The three major categories, their subcategories and interaction with the JCP are summarised in Table 10-1. The numbers in Table 10-1 refer to the section in this chapter in which the category is described in detail.

Table 10-1: Summary of psychiatrist categories

Psychiatrist Categories regarding TR	Interaction with JCP
10.1: Fulfilling my role as a doctor 10.1.1: Being responsible for all	10.1.2: Advocating for SUs
10.2: Building the Therapeutic Relationship 10.2.1: Establishing common ground 10.2.2: Reaching SUs	10.2.3: Not benefitting me
10.3: Influencing choice	10.3.1: Enabling true choice?

In this chapter, the findings focus on primarily on aspects of psychiatrists' roles and how that determines interactions with SUs. Like the CC chapter, this analysis suggests that psychiatrists are similarly hindered by structural factors in developing TRs.

10.1. Fulfilling my role as a doctor

Psychiatrists discussed many components of their roles, including aspects of being a doctor and being able to treat i.e., seeing a problem, conducting tests and finding solutions or treatment. All psychiatrists described evidenced based medicine (EBM) as the guiding framework of their practice, and as medically trained doctors a key focus was treating SUs with medication. Additionally, as psychiatrists within community mental health settings, they have a range of other roles including managing the multi-disciplinary team and statutory obligations such as being the 'responsible clinician'. Most psychiatrists described being answerable to the wider community and regulatory authorities. For example,

"I've got a statutory role now because I have 6/7 patients on CTO [Community Treatment Order]. So I have to be very clear about my role there as a responsible clinician which is to review the CTO, to be very clear to them about what the criteria are and to be answerable to the mental health act tribunal and fill in all the paper work. So that is a very specific role. I think the second role obviously is medication. Negotiations around medication. Making decisions about interventions I think are important. I suppose I have an overview of risk management. There are those. Then there is the psychological work, but I think the bulk of the psychological work is got to be delivered from the CCs actually."

(Male, London)

Often the most salient aspect of their role was the duty of care to the wider community and reporting into regulatory bodies; interactions with SUs or 'soft skills' were secondary for most psychiatrists. A minority of psychiatrists stated that interactions with SUs were the responsibility of CCs. Indeed, one psychiatrist believed that focussing on interactions and the TR with SUs would undermine the relationship between the SU and CC. For example,

"I think there is a danger, because I see less of them, of me developing a TR in a way that doesn't enhance the relationship with

the care coordinator as they are the ones that need to see them."
(Male, London)

For psychiatrists, a key challenge appeared to be the interplay between statutory roles and adherence to EBM, and being able to interact with SUs in a way that facilitated both the fulfilment of these roles and clinical beneficence. Some psychiatrists described how the fulfilment of their wider responsibilities came into direct conflict with SUs' wishes, for example, disagreement about medications or concerns about risk. Some psychiatrists described situations when the fulfilment of their role or their needs for a clinical meeting (such as ensuring the signs and symptoms of illness and compliance with medication were addressed), came at the expense of focussing on the SU's experience and the SU's defined needs. If there was a conflict or compromise required, the psychiatrists' wider responsibilities appeared to 'trump' focus on such interactional components. This is very similar to how CCs described how aspects of their roles prevented them from being 'person-centred' (see Section 9.1.3).

There were exceptions to this. Two psychiatrists emphasised the importance of interactions with SUs and the primacy of developing a TR. These psychiatrists believed that by focussing on the micro details of the interactions and actively trying to build a TR with SUs, they were fulfilling their role with SUs, which in turn allowed them to fulfil their wider responsibilities, such as those outlined above.

10.1.1. Being responsible for all

By focussing on the statutory or wider role responsibilities, it was clear that psychiatrists were concerned about managing risk. '*Being responsible for all*' was the first sub-category of '*Fulfilling my role*'.

Psychiatrists' responsibility to the community and the reputation of the psychiatric profession meant they felt responsible for keeping SUs well. Like CCs (Section 9.1.2), psychiatrists' views regarding management of risk were not restricted to questions of safety of SUs and others, but were extended to managing SUs' wider life and experiences, for example:

"But I think there always are risks involved. Depends on how you look at risk. I think people are always at risk of damaging their relationships, or losing their employment as a result of illness... so I think there always are risks involved it is about the severity of the risk."

(Male, London)

A minority of psychiatrists challenged this perspective of overall responsibility. As one psychiatrist suggested:

"I mean it's, I think this concept that we are looking after our patients is totally wrong. I think the patients, you get patients to discover that they are the ones that need, they need to sort of learn the tools and techniques to manage their own symptoms. And that's the way I see that, your role is you need to facilitate that and you really cannot look after someone, that's the myth."

(Male, London)

Consistent with CC views on 'positive risk taking', another psychiatrist talked about taking a step back in order to facilitate a SU's overall well-being:

"Sometimes we need to let patients go a bit if you know what I mean, give them some freedom to test things out. I think sometimes clinicians get anxious that something is going to go wrong. Actually occasionally you need to take a few risks for people to move on a bit."

(Female, Birmingham)

This is perhaps most clearly described as a conflict between SU autonomy and psychiatrists' views regarding clinical beneficence. All psychiatrists strongly believed in the benefits of medication for this group. Additionally, it was clear that psychiatrists were trained to act. Taking risks as described may be in conflict with EBM, treatment guidelines and prior training, but may also confer some clinical benefit. It was clear from this analysis, that while some psychiatrists were reconsidering the impact of their actions and role requirements on the overall well-being of SUs, most psychiatrists retained the sense of overall responsibility and described acting accordingly.

Only one psychiatrist described the importance of not taking action and allowing SUs to fail, in order for them to learn and take responsibility for their own lives.

10.1.2. Interaction of 'Fulfilling my role' with Joint Crisis Plans:
'Advocating for service users'

Multiple and competing requirements for psychiatrists often meant compromising on a SU's experience of meetings. One of the key benefits of the JCP intervention, from the psychiatrists' perspective, was that there was someone in the room who was explicitly looking after the SUs' experience. 'Advocating for SUs' was therefore the second sub-category of 'Fulfilling my role'. For example,

"I think what it did was it increased the strength of the advocacy that the patient had, because there was someone else in the room who was explicitly thinking about, concerns about whether the care plan was adequately shared, whether the patient was taking ownership over that care plan. And I think that, some of the CCs are very good at that, and some of them aren't so good. And sometimes perhaps I don't think about that enough. So I guess having an extra, it's like having an advocate in the room almost."

(Male, London)

As in the case of CCs, this example demonstrates that the wider roles that psychiatrists perform may not enable sufficient focus on SUs' experiences. While psychiatrists expressed a commitment to collaborative care planning (Section 10.3), overt reflection on whether the SU feels sufficiently involved may not be directly considered. As one psychiatrist stated,

"I think [the JCP planning meeting] is a useful opportunity... you know one is forced to listen more which I think we are all very bad at! Yep that is probably main gain from it. Your in... one is in a different role... it forces it to be more collaborative."

(Male, London)

In these ways, the JCP facilitated a manner of care planning to which psychiatrists aspired, but did not always achieve. They believed that the independence of the Facilitator was crucial in allowing this 'advocacy' role.

However, and like CCs, some psychiatrists expressed concerns that the JCP may interfere in the delivery of routine care and fulfilment of their roles. In particular, psychiatrists were concerned that the advocacy for SUs may create a difficult dynamic in the meeting that the psychiatrist would need to manage. For example,

"...and then if a researcher comes in and you know they're looking at a JCP, and you know cos they're discussing that with the patient, and they say well I never under any circumstances want to be sectioned again."

(Female, Birmingham)

"I suppose that would be a worry of mine, would be that, if you have... people who are outside the clinical team there is always the concern that you might end up kind of working against each other a little bit and then, kind of giving mixed messages or you know, and that could be confusing to people."

(Male, London)

"The first meeting felt a little bit more like it was somebody from outside kind of doing some research on, the sort of people, and at that time I guess that set a particular dynamic where somebody comes in and sort of interferes with the care, it feels like even though that wasn't the intention."

(Male, Lancashire)

In summary, for some psychiatrists, the JCP had benefit in enabling them to fulfil their roles and ensure collaboration. However, for other psychiatrists the initial impression was that it was unnecessary 'interference'.

10.2. Building the Therapeutic Relationship

Just like CCs, many psychiatrists defined a good relationship as one where the SU 'wants to see me'. That is, the measure of a TR is whether the SU was 'engaged' in treatment. Once engaged, it was then possible for the psychiatrist to fulfil their roles. Establishing a TR enabled the clinical work to be done; psychiatrists did not discuss interpersonal bonds with SUs when defining their TRs.

The precondition for engagement, (i.e., the measure of having achieved a TR), was '*Establishing common ground*'.

10.2.1. Establishing common ground

'Common ground' referred to a shared understanding of a need for care and an understanding or expectation from SUs that the psychiatrist would be able to help; this requires a level of SU insight and/or acceptance of their mental illness. Many psychiatrists described how (either themselves or the wider team) provided practical assistance with housing or finances in the early stages of a relationship or in the absence of insight, to prove their worth to SUs and to facilitate engagement. For example,

"Well I think if people see that there are other benefits... because if someone lacks insight 'why do I need to take medication, I'm not unwell' ... umm like I say, assuming the risks aren't great at that particular time, then we can try and make sure that we are seeing them and they are not disengaging by the practical means and along with that try and keep treatment on the agenda as well."

(Male, Birmingham)

When SUs lacked insight and did not accept practical help, psychiatrists expressed frustration at not being able to 'reach' them. However, as one psychiatrist pointed out, sometimes establishing common ground required SUs to accept a very difficult thing:

"There is a fundamental belief that 'I don't relapse'. [...] There is so much for these patients to lose by letting go of that. A huge amount to lose. So if you start letting go of that and start believing you do have mental illness that has bugged up your life for the past

decade or whatever... it is huge. So being able to impregnate, or get in there even to start shaking things around, there's often just this wall that you are bouncing off."

(Male, London)

Psychiatrists described these strategies as important in building trust, and in particular, trust that they would be able to help SUs. Additionally, psychiatrists believed that taking a broad approach (focusing on practical help in addition to medical help) illustrated a concern for SUs and their experiences outside mental illness. For example,

"I think err, what a good relationship would be, I think sometimes you have to talk the language that patients want. It is not, we focus too much on many medication and recovery. Sometimes it's as simple as writing a letter for housing or addressing their debt issue or you know trying to sort out the other pressures that they face in their life, that sort of language. And that's how you sort of build up that relationship. It's not, if you focus [...] too much on illness and err... medication I think that can become you know... patients don't want to hear about it all the time. Because it's hard enough for them, they have to live with that for the rest of their life"

(Male, London)

"[Establishing TR through...] listening and trying to understand where they are coming from. Trying to get to know in detail the sorts of problems they are presenting with – and that usually goes quite a long way. And consistency. So knowing them over a period of time. Getting to know other family, carers, other professionals involved and being sympathetic I guess as well."

(Female, Birmingham)

Another way in which psychiatrists proved their worth to SUs was through proving their expertise. For example,

"If they can see that actually something you've done or something that you've suggested has actually been of benefit to them, they might think well, they might know what they are talking about there – shows them some clinical judgement."

(Female, Birmingham)

10.2.2. Reaching service users

From the perspective of psychiatrists, the establishment of the TR through finding common ground and trust, facilitated open and honest communication. Conversely, several psychiatrists described feeling unable to understand SUs' responses to situations. *'Reaching SUs'* is therefore the second subcategory of *'Building the TR'*. For example,

"The level of dysfunction or lack of insight within many of our patients within a [Recovery and Support] team, makes them fairly impenetrable."

(Male, London)

"He was to get a photograph for a Freedom pass but he's never done it, even though it's like two or more years now. Err, I don't know how long it's been introduced to him to do that, maybe six to nine months, he's not got around to it. And it was hard to fathom what that was about."

(Male, London)

When psychiatrists were unable to reach SUs, they described ritualistic and unhelpful communication, quite similar to SU's reports on *'Playing the game'* (Section 8.4.1.1). For example,

"You get some patients that are given treatments, they know they're not taking them. And you sort of get the sense that the person who prescribes them knows they're not taking them. But nobody ever discusses that it just goes on and on for years and years. So sometimes it's, whilst that's an easier in some ways for consultation just to have them in quickly, but clearly that's very helpful for anybody. Everybody gets stuck with that."

(Male, Lancashire)

Psychiatrists most often explained that the difficulty in reaching SUs was due to the severity of the SUs' illness. For example, one of the more junior psychiatrists described not explaining side effects of the medication to SUs

as he thought they would be too unwell to understand. Similarly, a more experienced psychiatrist described choosing not to discuss problems with some SUs:

"There was nothing to be gained on crisis planning around talking about medication with this person. Because, from a past point of view, because his ideas about it are so influenced by his delusions and fairly rigid thinking... that a needle is somehow good for him... there is no point..."

(Male, London)

However, a minority of psychiatrists acknowledged that the difficulty reaching SUs may be due to deficiencies in their own communication, for example, through using very technical language or by 'pumping information' at SUs. These psychiatrists also took a long term perspective believing that it was always worth trying to discuss treatment decisions and illness issues.

"There isn't such a thing as patients who will not respond. Because ultimately, because psychosis is a journey one would assume that at some point in time if you kept asking the questions again and again, that they would think about it, and perhaps learn from what they... you know said and did before."

(Male, London)

There are aspects of psychotic illnesses that may hinder open communication, however, there may be other issues that prevent the good communication such as deficient communication strategies described by some psychiatrists in this study (see Section 10.3). Equally, though few psychiatrists discussed it, the inherent power differential in the relationship could be a barrier to transparent interaction. It was interesting that while no psychiatrists used the word, they described a sense of powerlessness in their interactions – for example, experiencing some SUs as 'impenetrable'. In other words, some psychiatrists felt that they couldn't affect a change in the SU's interaction with them. This is very similar to how many SUs described interacting with psychiatrists (Section 8.4.1).

10.2.3. Interaction of 'Building the Therapeutic Relationship' with Joint Crisis Plans: 'Not benefitting me'

Psychiatrists reported that they did not believe the JCP affected their relationship with SUs as many felt they already knew SUs very well and that trust and common ground had been established. However, they believed that the JCP may have been of benefit for SUs by showing them respect. Indeed one psychiatrist explicitly described how her presence in such a meeting would be beneficial to the SU,

"I feel that, meeting up with their consultant in this particular meeting it increases the bond between the patient and the consultant. That the patient sees that not only is the consultant seeing me, in the patient clinic but she's also come along to this crisis planning meeting. Because the patients always expect their CC to be with them anyway [...] But when they also see that the consultant has also come, and they feel that the consultant is in a way an ally with them [...] So it's good for the patient to have a familiar face in terms of a CC but it also helps, because the people who I sat with, my patients were really very happy that I had come and I gave my opinion."

(Female, Lancashire)

Similarly, the structured meeting provided an opportunity to convince SUs of the psychiatrists' commitment to them. For example,

"It's yet another thing where he's been shown a reasonable amount of respect and interest in his world and what he thinks and what he wants, and even if it didn't relate to, you know he could necessarily immediately think... well what's this? I'm never going to relapse again what's this about? He didn't entirely dismiss it in that way, I mean, but he kind of, I thought he received it, you know relatively kind of passive involvement with it. But it's part of the whole you know, it's another attempt of people to kind of show them some interest and respect and kind of, ideas about his views and what he wants. So it could be you know yet another thing that might be beneficial, might help him take on board that he does have some risk."

(Male, London)

However, the majority of psychiatrists did not believe they needed to be present during the meeting. Other than the participant quoted above, most psychiatrists believed that their presence was useful to ensure that important aspects were covered, but their presence did not confer any additional benefit for SUs. These views are perhaps a reflection of the current model of service delivery and preferences of psychiatrists (as discussed above), with CCs as the primary contact for SUs.

Most psychiatrists believed that the process did not differ from their usual approach, or provide any new insights about the SU and therefore did not affect their relationships,

"No that was the thing! That was the thing. I didn't really learn any more information about the patient at all. But then maybe that's just because the way I work, that's my... I'm very, very keen on trying to prevent [...] crises... All the sort of relapse stuff and early warning signs is really really key and getting them to be you know, I suppose to build up that relationship with them so that they can ring us up and say, I'm not feeling so good. And so you can intervene early really."

(Female, Birmingham)

The structured communication of the JCP might interact with the development of the TR as described by psychiatrists, by building common ground and trust through improving insight and/or making commitments. However, none of the psychiatrists mentioned such effects and therefore it did not impact on their view of the TR. Rather, psychiatrists described how it provided an opportunity to show the SU respect – thus, in their view, enhancing the SU's view of the TR.

10.3. Influencing choice

While all psychiatrists expressed a commitment to collaboration, there was variation in how this was done and the strategies employed. A key component of collaboration is SU choice. In this context, '*Influencing choice*' is the third major category identified in the psychiatrist data.

Some psychiatrists acknowledged that encouraging SU choice is a change from how they were trained and how they have practised previously. For example,

A *Cos if you don't ask questions those kind of questions of [...] patients, if we don't offer the choices... you know choice is an important thing. I think the way you're trained is that too many choices can cause more, conflicts. So try and sort of limit the choices. So this is a pretty new refreshing way to look at things.*

R *So that's not done very often in services?*

A *I don't think so, I think this is something pretty new that psychiatrists are coming round to in terms of offering choices and, you know, even when we use, talk about a treatment for that matter, I think we're coming to a stage now where we offer the treatment and leave it to the SUs to make up their minds.*

(Male, London)

'SU choice' was a concern for many as they were concerned about the potential conflict with clinical beneficence, particularly in relation to medication. A few psychiatrists expressed equally strong concerns regarding SU choices that may undermine their autonomy, such as wanting increased assistance from services.

While psychiatrists all described themselves as advisors and reluctant instructors when necessary, many described using different strategies to influence the SU to make a sensible choice. For example,

"When I meet the patients, I explain to them what a consultant is. 'I am your consultant and am the person who you consult for expert advice. You are in charge'. It is more or less what I tell them. You come to see me and I am your expert. You're the king in this situation and I am your counsel. I will implore you, at times, to follow my advice like good counsellors would to previous kings and queens. But it is down to you."

(Male, London)

"[Advice giving is] my main role. Yes that's right and I usually tell the patients it's a very good way of approaching our patients, because I'm say I'm here, trust my advice. Whether you like it, take it, surprisingly they usually like to take advice."

(Male, Lancashire)

In both of these examples the psychiatrists describe their approach to promoting SU choice as advising, however, there are very clear directives in each example. By 'imploring' or telling services users to 'take it', the psychiatrist ensured their role requirements were fulfilled. Furthermore, in the King's Counsel analogy, it is the King who has an unequivocal power to make decisions; the counsellor may implore the King, but the King retains ultimate choice. The difference in mental health is clear. The MHA determines that clinicians have the ultimate power; imploring, therefore, may have a very different effect.

Most psychiatrists described how 'advising' was enabled by a strong TR. However, one psychiatrist described how the establishment of a TR enabled him to instruct the SU. For example,

"Sometimes you can be more directive if you've built up some trust and they kind of have some, maybe... I think if you're directive when there's no connection then that can be a bit err, counter productive. But when there's a kind of trust and there's, they kind of accept that we might have something to say of interest. Because we've paid due attention, we've turned up, we've... and also the CC often have done quite a lot of help on the practical side. So there is a kind of engagement then... and so you sort of judge it according to where you're at."

(Male, London)

In the majority of cases, psychiatrists described methods they had used to ensure SUs complied with treatment recommendations. A few psychiatrists stated that they could not make SUs comply and that SU choice should be facilitated even when the psychiatrist believed the choice was not in the

SU's best interest. By enabling SU choice the psychiatrist demonstrated respect for the SU and facilitated learning. For example,

"Well I view psychosis as a journey, it isn't something like a quick fix and that's it, and most patients should be allowed to fail, that's the way I view it. [...] Say in an admission sometimes it may take a year or two years for a client to realise that perhaps the choice they made regarding whether not to take medication or to take medication or change medication may not have been the right one. But that's allowing the client to fail."

(Male, London)

Allowing SU choice that may result in relapse may run counter to psychiatrists' training and role requirements. Most psychiatrists appeared to compromise by presenting limited choices and using interpersonal pressure (such as imploring). For example,

"So I give them two, usually it is a choice, sometimes there is no choice. I'd say you've only got one way to go, this is the only recommendation I could make. Um... by and large, there is a couple of choices... I have my personal beliefs about why that might be better and that be based on publications, it might be based on personal experience, it might be based on side effect profile – all sorts of reasons I'd explain to them. But the difference between the two, who knows? On balance it is this one but you know this one might be better? I might be wrong on the way I've added this up. If we knew everything about it, we wouldn't have the problems we have today. We don't have perfect medicines. We don't have perfect diagnoses. So... on balance I recommend this, so they won't have an option that I don't agree with. Ok but if they say to me that I don't want to do any of those, I can't force them to do anything. I can say 'no I'm going to prescribe you this medication' and they can say well I'll go home and I won't take it and I won't bother coming to see you in 3 months time or whatever. And we'll have a bad relationship."

(Male, London)

It is clear that enabling SU choice is not a straightforward proposition for psychiatrists. There are two main areas of difficulty: firstly, their verbal

commitment to choice and advising may be undermined by their interaction style; and secondly, the concern that SU choices may conflict with their view regarding the SU's best interest, both in terms of decisions that promote and those that undermine autonomy.

10.3.1. Interaction of 'Influencing choice' with Joint Crisis Plans: 'Enabling true choice'

Many psychiatrists did not perceive a difference between their normal practice and the ways in which the JCP enabled choice. One difference acknowledged by a few psychiatrists was that by controlling information flow (i.e., through 'active elicitation' of SU views), they were forced to listen more and in this way the intervention 'forced collaboration'. However, as so few psychiatrists believed they learned anything new about SUs, this forced collaboration did not improve the information obtained.

A more fundamental concern regarding the JCP related to the discussion about the conflict between choice and beneficence. For example,

"Whereas it's often the people who come in with their laminated crisis plan who are the ones you think this is actually being more counter productive in this particular patient's case because they're using this explicitly as a way to wield power in this situation. That is fine, because I'm all for patients having power but it's doing something more than that and it's allowing them to negotiate both say what diagnosis they want or how they wish services to relate to them. In a way that might from another perspective might seem quite counter productive, both for them and for services."

(Male, London)

Like CCs, some psychiatrists were concerned that as the available care pathways may be quite limited, and the JCP could be 'trumped' by the MHA, the JCP was in fact providing false hope for SUs. For example,

A *So... so perhaps we haven't focussed enough on, thinking with people about what they don't want to happen in crisis, I think that could be true. But it's clearly an extreme complicated area. You know... erm...*

R *In terms of capacity?*

A *Yeah what constitutes capacity? What constitutes something that someone can really refuse in it, you know I mean obviously if someone say doesn't want ECT that's very straightforward at one level, because it's controversial for many psychiatrists so you know but... I don't want to be sectioned, I don't want to be... you know given [an anti psychotic], these are more complicated things for a patient to demand and it's not, and obviously the Mental Health Act trumps the capacity act in these incidences. So you know do you want to open a whole can of worms where possibly in crises you won't necessarily be able to follow through on the person's wishes. And then perhaps they feel cheated on something they feel that they'd asked.*
(Male, London)

"You see this is the problem. We're doing the Joint Crisis Plan, but then we're dictating the patient what we can offer. [...] He doesn't really have a choice, if he deteriorates then the only help he will get is through the pathways that is currently being commissioned. If for instance [the SU says] 'if I deteriorate I would like to, err... see the care coordinator straight away', that's not an option. The option is to see the crisis team practitioner, doctor straight away, [...] that's the problem you have, we don't have 100s interventions. You've got five of them which is usually offered to the patients, care pathway. So in my opinion what were the patients choosing? And this is why possibly nobody has come to me with a crisis, because the JCP includes the pathway that we've not got.[...] Okay, what other choices do we have? Mm, not much."
(Male, Lancashire)

Additionally, psychiatrists described how often the clinician dealing with a crisis situation would not be the clinicians involved in developing the JCP. In this context many psychiatrists discussed being unable to ensure that the choices made by the SU would be honoured.

"It's not necessarily you who's there on a Friday night trying to find the bed to do the... to sort of go through with that crisis plan, which then of course erm, the foundations of the crisis plan are ropey aren't they if you can't actually do what's agreed. Then... then everybody loses some faith in the point of doing it I suppose."

(Male, Lancashire)

Another concern raised by psychiatrists was the extent to which SUs have the capacity and/or desire to make choices and engage in meaningful discussions about their illness. For example, as a psychiatrist working in a Recovery and Support Team said,

"Because... some patients just take the medication and monitor themselves because, in a very old fashioned sort of way, they trust the doctor. You know what I mean. [...] You get patients who you want to explain what it is all about and they go 'no no it's fine doc. You think it's fine? That is all I need to know'. You know. Um. For them... they are probably wouldn't be appropriate for that intervention because they don't care, they don't want to know, for them the way of managing it is crisis specialist and doing the things they are told to do."

(Male, London)

Likewise, an Early Intervention psychiatrist said:

"But it's a little bit difficult for people to put across their views and needs on that, their ideas of what their needs are for that when they haven't got to the place where they are willing to acknowledge that they might be needful in that way."

(Male, London)

Another psychiatrist thought that SUs didn't fully appreciate that they were able to have a contrary view, or were able to disagree with his recommendations:

"Erm, I mean, I don't think it was less helpful, but in some ways it could be seen by some to be. I think one or two patients just said yes, so it was not that they were disagreeing with me in anyway and

I'm not sure how much they took on. What was being offered to them by way of an alternative you know?"
(Male, Birmingham)

In this context, further questions are raised about the implementation of the JCP intervention, as the model aims to empower SUs to actively express their own views.

The JCP did not address significant concerns or potential conflicts that many psychiatrists perceived in relation to SU choice. Indeed, by emphasising the primacy of the SU's perspective, the intervention may have inadvertently heightened these concerns. Conversely, one psychiatrist in London thought that despite reservations about the suitability of SUs, the JCP was a useful exercise:

"I think with people with chronic schizophrenia and erm... and anyone who has, anyone who is best formulated as having an axis one psychosis, would benefit from autonomy being promoted and err... and or us being reminded that we shouldn't forget it. Because it can so easily get forgotten, particularly people with chronic and residual symptoms."
(Male, London)

10.4. Chapter summary

Preferring to have an oversight role, most psychiatrists did not focus on the interactional components of relationships nor did they appear to account for the power dynamic in interactions with SUs. In contrast to the CIS analysis, psychiatrists expressed few needs of an interpersonal kind. Rather, professional roles and associated needs were emphasised.

Psychiatrists did not perceive any fundamental difference in their routine practice and the JCP intervention and therefore did not perceive its potential importance or impact.

Stakeholders in the JCP meetings may bring a complicated history of past experiences, political views about illness and treatment, beliefs about their

role and requirements in the meeting, and different needs. These factors mean attendees at the JCP meeting with nominally the same agenda (that is of care planning), may have different and perhaps competing needs or priorities. From the psychiatrists' perspective, most understood that their professional needs sometimes compete with those of SUs, and will take the risk averse path to enable role fulfilment, possibly at the expense of 'explicitly' focusing on the SU's experience. Although they expressed a strong commitment to collaboration, the analysis suggests a lack of understanding of the impact of their communication style with SUs and how that may enable or prevent 'true choice'. In this study, psychiatrists illustrated how feeling responsible may lead them to override SU choices if they perceived that choice was not in the SU's best interest. Indeed, psychiatrists have the legal capacity to take control, but also may use interpersonal influence by virtue of their position as an authority figure. Yet, the psychiatrists in this study did not appear to be conscious of this influence. In this way, and consistent with the CIS analysis, true SU collaboration may be seen as an ideology that is difficult to achieve.

Most psychiatrists did not perceive that the JCP intervention required a change in their normal style of interacting. They also did not believe they needed to be present in the JCP meeting other than to ensure certain aspects were covered. They did not believe they learned anything new and therefore questioned the benefit or impact of the intervention. Additionally, their concerns about the potential interference of the Facilitator and the ability and/or willingness to honour or agree to SU choices created ambivalence towards the intervention.

In summary, the implementation of the intervention was undermined by failing to ensure firstly, the true engagement of psychiatrists (and possibly some SUs) in the process and secondly, a focus on the more micro aspects of interactions in care planning. Psychiatrists did acknowledge some differences between the JCP approach and their routine practice, however, these were presented as minor and not impacting on the performance of their role. They believed that the SUs themselves may have benefitted, but they did not.

Many psychiatrists did not agree to be interviewed for this sub-study. However, there were examples from the SU and CC transcripts of a more overt undermining of the process than described in this chapter.

11. Model of Therapeutic Relationships and the impact of Joint Crisis Plans

The preceding chapters presented the views of the three stakeholder groups (SUs, CCs, and psychiatrists) on the JCP intervention and TRs. In this chapter, the three perspectives are combined to present a theoretical framework/model of TRs in community mental health settings drawing on Structural Symbolic Interactionist, and Role and Identity Theory. There are four main sections to this chapter:

- The rationale and approach to the further analyses undertaken for this chapter.
- The outcome of the analyses: the model describing TRs.
- The interaction of the JCP and the model.
- The differences between the proposed model and existing theories.

11.1. Further analyses

In the preceding chapters, a reasonably consistent view of the factors underpinning a helpful TR was presented. All three groups agreed that aspects described by CCs as 'person-centred', or by SUs as '*Being known as and individual*' and '*Being heard*' were crucial to the development of a strong TR. All groups used the word 'respect' to characterise the interactions of a TR. Additionally, for all groups, trust appeared to be a key indicator or indeed, outcome, of whether a strong TR was developed; for example, clinicians described trusting SUs sufficiently to take 'positive risks'; and SUs described trusting that clinicians had the expertise and consistency to help them in a crisis situation. Importantly, there were clear contextual issues for all groups that defined and directed the development of TR. For SUs, past experiences in MHS determined how they approached clinicians and TRs. For clinicians, maintaining their professional role appeared to conflict with maintaining or acting in a manner to ensure the development of strong TRs.

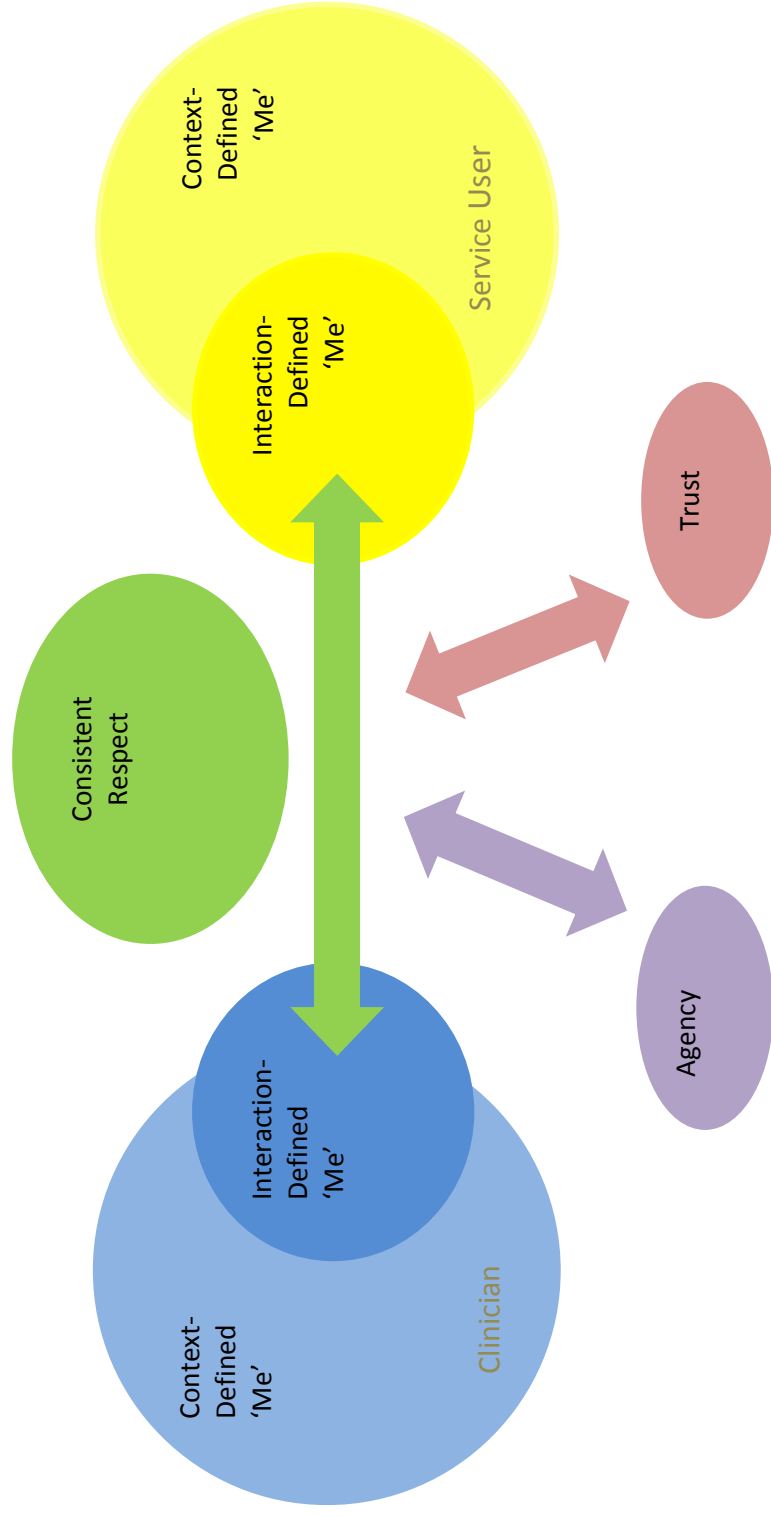
Analysing the individual perspectives therefore illuminated some shared views. Considering individual perspectives is useful to understand the lived

experience, and indeed is generally how research is conducted in this area (see Chapters 3 and 4). However, it is the intersection of these lived experiences that ultimately define TRs. In this context, the analysis progressed beyond individual perspectives to consider the system as a whole. Using constant comparison methods (Section 6.4.2.4), major categories presented in the preceding chapters and other minor categories were compared and contrasted across the three stakeholder groups. Memos were written and diagrams and maps were drawn to link new categories in a theoretical framework. The output of this further analysis – the model of TR– is described below.

11.2. Model of Therapeutic Relationships

The analyses suggest a framework of five key categories which define and determine TRs: *Consistent Respect*; *Interaction-defined 'me'*; *Context-defined 'me'*; *Agency*; and *Trust*. Each of these categories are explained in detail below, but briefly, the framework suggests that TRs are ongoing processes involving the bi-directional demonstration and assessment of *Consistent Respect*. An individual's assessment of *Consistent Respect* is determined by the behaviours of the other. This behaviour is determined by pressures and experiences from the wider context (that is, the *Context-defined 'me'*) and an appraisal of the behaviours of the other (that is, the *Interaction-defined 'me'*). The outputs of a TR characterised by *Consistent Respect* are *Agency* and *Trust*. Once an assessment of *Consistent Respect* has been made, *Agency* and *Trust* may also feedback into the process. This process is illustrated in Figure 11-1: Model of Therapeutic Relationships.

Figure 11-1: Model of Therapeutic Relationships



11.2.1. Key concept: Consistent Respect

As discussed in Chapter 1, the TR is best considered an appraisal of the other person and the interaction. This analysis suggests that in community mental health treatment, helpful TRs are those appraised as demonstrating *Consistent Respect* (defined below). Importantly, and as illustrated in Figure 11-1, the demonstration is bi-directional, that is all participants/stakeholders appraise their counterpart's behaviour.

Consistent Respect comprises two components: firstly, an appraisal of the manner in which the other person is behaving and whether this demonstrates *respect* for the appraiser; and secondly, an appraisal of whether the other is reliable, through assessment of the *consistency* between their talk and action. *Respect* is demonstrated by the kind of individualised care captured by the categories of '*Being known as an individual*' (Section 8.2.1). *Consistency* is required in all spheres of interactions: in the immediate interaction; between what is said 'now' and what is done in the future; and between what is said and the actions determined by policy, professional role or needs.

A lack of consistency was a fundamental barrier to the development of TRs. For example, SUs who entered into MHS at a time when the model was to focus on maintenance (see 9.1.1) expected to be able to access regular, intensive and supportive care. However, this analysis suggests that the model/goal of MHS may be changing (or, at least, is poorly defined) and that services are not able to deliver this intensity of care. The effect of this inconsistency is that SUs felt disrespected because their needs were not met (see 8.2.3). Similarly, the lack of consistency between clinicians' rhetoric (such as encouraging choice) and actions they took to fulfil role requirements, was interpreted as inconsistent and thus prevented the development of strong TRs. As discussed in Chapters 9 and 10, CCs and psychiatrists discussed elements of their role that were often prioritised over interactional concerns, creating inconsistency between their stated goal/approach and the SU's experience of the interaction.

The SUs in this study described a number of responses to a lack of *Consistent Respect* including a lack of honest and transparent communication (i.e., 'playing the game'), disengagement, or influencing through others by making complaints or using advocacy. Any of these responses represented a breakdown of the TR and perhaps a belief that they were not entitled to be shown *Consistent Respect* (see 8.3.1) and reflective of their capacity for *Agency*.

Equally important to the development of TRs were clinicians' appraisals of whether SUs demonstrated *Consistent Respect*. Clinicians required and sought acknowledgement of their expertise (and indeed SUs required this as discussed in Section 8.2.3.2). Often the clearest demonstration of respect was the achievement of 'common ground' (see Section 10.2.1). However, this demonstration of respect appeared to be insufficient for the development of the TR. Rather, clinicians required engagement in care and honouring of commitments i.e., consistency. For example, a clear breakdown in the relationship occurred when SUs did not honour care plans, including the JCP. As opposed to SUs, who in most cases appraised perceived clinician inconsistency as an indication of their own deficiency, most clinicians responded to inconsistency with resignation, that is, it was not worth attempting routine care planning or JCPs as SUs deteriorated too quickly and lost the capacity for honouring previous commitments. This rationale had the effect of allowing the clinician to remain involved with the SU, but it also decreased the clinician's expectations of SUs' *Agency*. By accepting that the SU was not able to be responsible or have *Agency*, respect decreased. Similarly, SUs needed a sense of *Agency* to fulfil commitments made in care planning e.g., that they could and should take responsibility. However, the analysis suggests that clinician inconsistency in talk and action undermined SU's sense of *Agency*.

In summary, this further analysis suggests that the demonstration of *Consistent Respect* needs to be bi-directional and consistent to work effectively in creating a TR.

11.2.2. Feeling respected, respecting self: the *Interaction-defined 'me'*

For SUs, the display of respect in the JCP Planning meeting appeared to elevate their interpretation of self from someone who was acted upon, to someone who was worthy of clinicians' time and worthy of having a voice. Additionally, by engaging in the discussion and permitting SU *Agency* and making a commitment to honour SU's choices, clinicians demonstrated *Consistent Respect*. This further analysis suggests that these demonstrations led to improvements in the SU's sense of self. *Interaction-defined 'me'* is therefore a key category within the model. The central proposition, drawing on Rogerian^{79;80} and Symbolic Interactionist perspectives,^{13;15} is that the SU's sense of self is partly defined through interactions with clinicians. Rogers described how therapists model self-acceptance for patients through 'unconditional positive regard'. Additionally, Symbolic Interactionist theory suggests that firstly, individuals act towards objects (including the 'self') depending on the meaning that object has for them and secondly, that this meaning is derived through interactions with others. In the proposed framework, if the clinician demonstrates *Consistent Respect* to the SU, the SU redefines the meaning attached to their sense of self as being worthy of respect. Similarly, a lack of *Consistent Respect*, was interpreted by the SU as evidence that they were not worthy of respect. This is illustrated in a quote from Chapter 8:

"The thing about when you're consistently treated badly is you expect to be treated like that so it doesn't...you're sad about it but it doesn't, it's what you're used to."

(Female service user, London Focus Group 3)

For clinicians, interactions with SUs were also important in their definition of 'self' – particularly in terms of professional role. If SUs demonstrated *Consistent Respect* through their interpersonal interaction and through adhering to the clinician's treatment recommendations, the clinician interpreted this as evidence that they were performing well in their role; that they had expertise. This in turn enabled them to perform in their role i.e., it gave them a sense of *Agency*. However, if the demonstration of *Consistent Respect* was lacking e.g., through the SU not adhering to treatment and not discussing their experiences openly, the clinicians felt powerless (see Section 10.2.2) and unable to act. In this way, and

consistent with the findings from Chapters 3 and 4, the measurement or appraisal of the TR for the SU is based on the emotional output of the interaction; for clinicians it is the behavioural results of interactions (e.g., SU engagement).

The 'me' presented to the other person in interactions was also partly defined by the impact of wider contextual factors.

11.2.3. Impact of structure and role: *Context-defined 'me'*

The model suggests that one of the key determinants of TRs is the impact of the wider context on the 'me' presented in interactions. For SUs, their personal history, and for clinicians, policy and role requirements were influential in determining how individuals interacted in and appraised routine care and the JCP intervention. The category of *Context-defined 'me'* captures the impact of such structures on the TR.

To each interaction with the MHS, SUs brought a sense of self as defined by past and present interactions within the wider community and MHS, and also a sense of self in terms of defined role – that is, what level of agency they felt they deserved or were capable of (see Section 8.4.1). Similarly, the category of '*Clinicians doing their job*' (Section 8.2.3) illustrated how SUs brought both a conception of 'clinician' and a set of expectations regarding how the clinician should interact with them, often defined by past negative experiences (see Section 8.1). Likewise, the analysis clearly presented clinicians' interactions with SUs as being partly pre-defined by the wider context of policy and responsibilities, and indeed each individual clinician's conception of the meaning of their role. The expectation of 'common ground' (Section 10.2.1) illustrated that clinicians also held beliefs about how a SU should engage or interact with them in their professional role. Furthermore, the sub-category of '*Ritualised Interactions*' (Section 9.3.2) suggested there was little novelty in interactions, but rather actors adhered to an established set of norms. In this way, the analysis suggests that each stakeholder has conceptions of their own role and how they can or should behave, but also expectations of how the other should behave in the interaction. These expectations appear to determine the appraisal of others

and the interaction, however, conceptions of their own role appeared to determine the 'self' or 'me' presented in the interaction. The concepts 'Role' and 'Identity' help to explicate this finding.

Blumer's conception of Symbolic Interactionism (SI)¹³ proposes that all meanings are derived in the immediate interactions between individuals or groups of individuals – that is without reference to the wider structural context. In contrast, Stryker's framework of *Structural SI*, which he describes as 'society shapes self shapes social interaction'²²⁹(p19), attempts to account for the impact of structure through application of *Role* and *Identity Theories*. Stryker proposes that individuals take on '*positions*' which are any socially recognised categories of actors in society, such as 'wife', 'doctor', 'poor man', or 'intellectual'. The concept of '*role*' is then defined as the set of expectations attributed to those positions. Those expectations are derived from past experience and normative assumptions made by the wider community. Thus the position of 'doctor' comes with a set of expectations regarding the level of qualification and expertise, of being able to help and of having power and influence. The position of a SU with psychosis comes with a set of expectations regarding illness, possibly inconsistent behaviour and needing to be helped. Similarly, for each stakeholder, there will be multiple *positions* and *roles*. Stryker further delineates '*Identity*' to describe an individual's internalisation of these *positions* and *roles*. Individuals may invoke different identities in interactional contexts depending on the salience of that particular identity or their commitment to that *role*.

In this way Stryker's work provides a theoretical basis from which to understand the model of TRs described in this chapter. In particular, clinicians have multiple identities incorporated into their sense of self as professionals. These multiple identities can be seen as a reflection of the multiple or pluralist identities at the macro level of the MHS. That is the MHS is perceived by different audiences (e.g., SUs, other professional groups, the government and the wider community) in different ways. For some SUs, it is a therapeutic entity supporting them to stay well; for other SUs it is a mechanism for controlling them. For the wider community, the MHS is often seen as an instrument of safety and control. For a

government, it may be seen as the delivery mechanism of its political agenda. Additionally, interacting with this is the meaning of MHS and the NHS in terms of ideology of care. For example, increasingly individualistic societies are requiring individuals to take responsibility for themselves. These multiple identities at the macro level of organisation, filter down to clinicians and to some extent SUs.

Stryker proposes that while individuals may enact multiple identities in an interactional context (e.g., healer, supporter, agent of control), an individual will prioritise one due to its salience for that individual or the implications of not doing so in the wider relational context. The analysis suggests that for clinicians the identity with the most salience was often that which allowed them to perform the role which met the needs of the wider organisation of MHS. In Structural SI terms, performing this role with established normative expectations from the wider community and their sense of self, had more positional power and salience than role enactments that focussed on SU experiences; therefore, the clinician acting within the context of the MHS would most often determine the mood and direction of the interaction. In this analysis, *Context-defined 'me'* appeared to facilitate repetitive un-personalised interactions, which were defined by the professional context. The sub-category of *Ritualised interactions* (Section 9.3.2), can therefore be seen as a prioritisation of one particular identity by clinicians, meeting the needs of MHS to be 'professional'. SU expectations of particular interactions, provided further evidence for the impact of *Context-defined 'me'* on the interactions. Many SUs felt unable to introduce change, but rather expected roles to be enacted, and acted according to these expectations (see for example, '*Playing the game*'- Section 8.4.1.1). This analysis suggests the wider structure may hinder 'new lines of action', and prevent personalised interactions that are characteristic of *Consistent Respect*.

In summary, the more influential the '*Context-defined 'me''* became, the less likely that TRs were appraised as delivering *Consistent Respect*.

11.2.4. Developing Trust

Trust is both an input into and an outcome of the process of developing TRs. In terms of *Trust* as an input, clinicians described it as a pre-requisite for TRs and had a number of strategies to build trust in the initial stages of developing relationships. Similarly, SUs described assessing the expertise of clinicians in order to determine whether they were 'doing their job', and whether it was worthwhile engaging with them. In this way, *Trust* could be considered a pre-requisite for TR. Equally important, particularly in terms of the demonstration of *Consistent Respect*, were the ongoing behaviours that facilitated or undermined *Trust*, however, clinicians in this study rarely discussed ongoing strategies for sustaining trust once achieved. Conversely, ongoing behaviours that strengthened or weakened trust were a key concern of SUs. For SUs the key threats to the development of trust were the inconsistency in the approach between different clinicians and inconsistency between individual clinician's talk and actions. In this context, SUs' appraisals of clinicians were an ongoing process.

This analysis also suggests *Trust* was an output of the TR. In particular, the demonstration of *Consistent Respect*, facilitated the development of *Trust* in the other actor. For SUs, a demonstration of *Consistent Respect* meant that they could trust the clinician to act both with expertise, and with the individual SUs' best interests in mind. For clinicians, the demonstration enabled them to trust the SU and perhaps take some risks in the future, knowing that the SU was engaged with them and would approach them if in need.

11.2.5. Developing Agency

The demonstration of *Consistent Respect* appears to promote *Agency* in SUs. *Agency* in this context is defined as the ability to determine one's own experience. As described above, inconsistency in clinicians' talk and action led to SUs in this study feeling powerless to influence their own experiences. Conversely, consistency built self-respect (Section 11.2.2) and a notion that they were entitled to/capable of *Agency*. As one SU said,

"[The JCP] was probably quite a healthy exercise in terms of reminding me that I was entitled to a degree of control, if that makes sense?"

(Male, Birmingham, Individual Interview)

Clinicians supporting SUs' choices facilitated the development of *Agency* by allowing SUs direct determination of their own experience. However, the description of the conflict between SU choice and beneficence, clearly illustrated that this was not a simple proposition for clinicians. Using the framework above, psychiatrists described one of their identities as 'advisors', however, with a few notable exceptions, the identity as 'instructor' had more salience and was therefore enacted more routinely.

As briefly described in Section 11.2.2, clinicians' *Agency* was improved by the demonstration of *Consistent Respect* from SUs as it was interpreted as evidence that the clinician has expertise, skills and knowledge to perform their role, thus facilitating further enactments of this role.

Additionally, the framework suggests that *Agency* may also be an input into the process. By promoting and facilitating SU *Agency*, clinicians may be able to ensure *consistency* in action; as *Agency* facilitates an ability to determine one's experience and a sense of responsibility. For example, one CC described how a psychiatrist sent a letter to a SU who had disengaged, reminding them of the contents of their JCP. This SU then re-approached the team and re-engaged with treatment.

11.3. The impact of the Joint Crisis Plan intervention

11.3.1. The planning meeting

The JCP intervention interacted with each of the stages in the model proposed in Figure 11-1. The planning meeting was an opportunity to demonstrate *Consistent Respect* for both parties in terms of interacting and making future commitments to honour the JCP. Using the model of TRs proposed (Section 11.2), a successful implementation of the JCP planning meeting required a '*new line of action*', that is a break in the established expectations and role enactments of both clinicians and SUs. If successfully

achieved, the planning meeting improved SUs' sense of self-respect via the mechanism outlined in Section 11.2.2, and in turn may have promoted increased *Trust* and *Agency*. This certainly did occur for some SUs who reported feeling in control and listened to, and clinicians being 'more reasonable than usual'. However, the analysis suggests that this '*new line of action*', or limiting of routine role enactments, was not always successfully achieved. In particular, through problems in implementation, clinicians did not always appreciate that their routine *role enactments* were antithetical to the model proposed and/or engage fully (or at all) in the process due to concerns about it interfering with routine care. The latter point is also illustrated in the failure of some clinicians to attend JCP meetings (as outlined in Section 7.2.4). Likewise, for the SU, successful implementation required a potential shift in their routine role enactments in terms of active participation in deciding the contents of the JCP and also, a commitment to honour the JCP themselves. A few clinicians expressed concern that SUs did not do either. When routine role enactments were not limited, the JCP planning meeting did not stand out as a '*new line of action*' and did not facilitate the demonstration of *Consistent Respect*.

In this context, the implementation of the JCP intervention, which should have altered routine role enactments and created a '*new line of action*', appears to have been flawed in some cases. This is despite high levels of fidelity reported in Section 7.2.3 and is discussed further in Section 13.4.

11.3.2. The use of the plan

After the planning meeting, the use and honouring of the plan was an opportunity for SUs and clinicians to demonstrate *Consistent Respect*. This aspect of the intervention was without oversight of the JCP Facilitator – and thus, in many respects, was a return to routine care. The analysis suggests a number of barriers to the use and honouring of the JCP in routine care, i.e., to demonstrate *Consistent Respect*. Figure 11-2 illustrates many of the barriers.

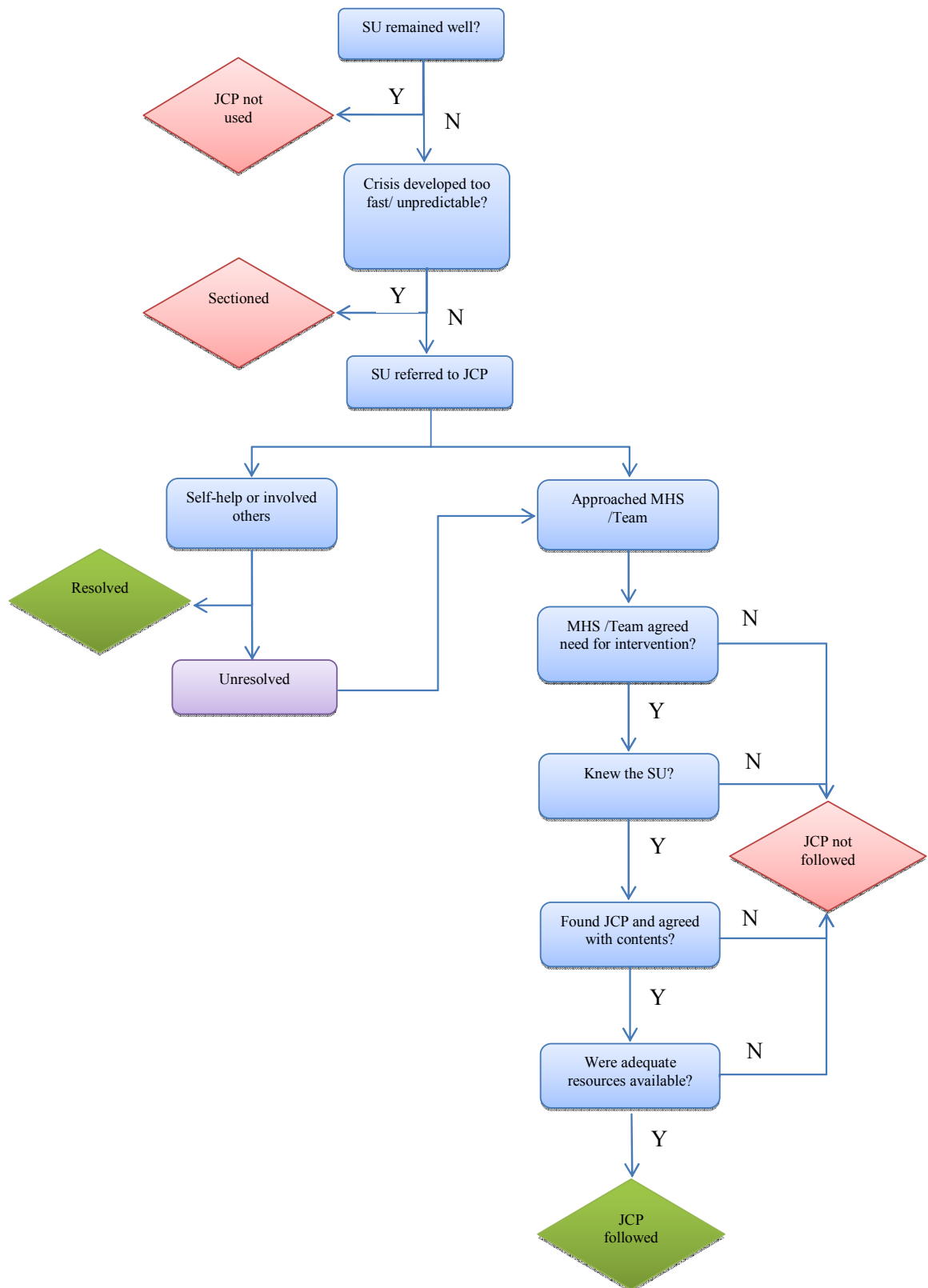
In the model proposed, the difficulties illustrated in honouring the plans would undermine the development of TRs. For those SUs who tried to use

their plan and experienced difficulties at some point in the path illustrated in Figure 11-2, they felt that their trust in the process and clinicians had been misplaced. The reversion to routine role enactments and the lack of honouring of the JCP content decreased any gains SUs had achieved in *Agency*. Conversely, the honouring of the plan either by clinicians or by SUs, had the effect of enabling a sense of overall control.

11.3.3. The Joint Crisis Plan as a systemic intervention to build Therapeutic Relationships

As discussed in Chapter 5, the ideology behind the JCP intervention is systemic – that is, by involving all stakeholders in the discussion, change is more likely to happen. In systemic terms, the JCP Facilitator acts as the therapist, attempting to build and strengthen the relationships between the stakeholders, rather than build relationships with individuals. It is clear from this analysis and from the perspective of most SUs, the Facilitators were successful in doing this. The Facilitator was rarely mentioned and only if the SU perceived a problem with their performance. Conversely, the JCP Facilitator was regularly mentioned as a fundamental component of the process for both CCs and psychiatrists – but in different ways. For CCs, rather than seeing the Facilitator as an enabler but not a group member they viewed the Facilitator as the key to success. Through deficiencies in the implementation, illustrated by CC reports of being lacking involvement in the JCP (Section 9.3.3.2), the Facilitator became part of the group. Conversely, psychiatrists tended to view the Facilitator as an advocate, balancing the power differentials and ensuring the views of the SUs were heard. However, there were examples of psychiatrists talking about the Facilitator ‘forcing’ their view, understanding the clinical situation and therefore not intervening. In this way, it is possible that the JCP Facilitators did not always deliver the intervention as intended, that is an observer and facilitator to the process of interaction, not, for example, a participant who builds a relationship with group members (discussed further in Section 13.4).

Figure 11-2: Process map of use of Joint Crisis Plans



11.4. Consistent Respect and other models of Therapeutic Relationships

This analysis clearly supports elements of the Rogerian^{79;80} model of TRs and the benefits of demonstrating unconditional positive regard. It also builds on work by Frank⁸⁷ (described in Chapter 2), in terms of explicating the bi-directional component of the relationship and the determining factors brought by clinicians and SUs to the interaction. Similarly, the requirement for expertise described by SUs, supports Frank's model of the TR. The two components of *Consistent Respect* (that is the interaction and consistency between talk and action) also reiterate aspects of Bordin's tripartite model⁸⁸ (see Chapter 2). *Consistent Respect*, however, extends these three models by widening the focus to both stakeholders and the factors determining the interactions. TRs viewed in this way, and from a Structural Symbolic Interactionist perspective, are therefore best understood as an ongoing process involving assessment and interpretation from both the SUs and clinicians. Importantly, and perhaps unique to the setting of community MHS, TRs are clearly influenced by variations in policy and community expectations, and therefore it is important to consider the structural impacts on interactions. Additionally, and as distinct from psychotherapy, the model requires that clinicians act. In psychotherapy settings, the 'work' is usually confined to therapy sessions. In community mental health settings, the work continues outside of meetings e.g., some SUs require access to assistance outside of hours or routine appointments. The proposed model incorporates this need for action from clinicians.

11.5. Chapter summary

This chapter has presented a new model for understanding the development of TRs in community mental health settings. The key point of interest is that actions of each stakeholder are interpreted by their counterpart, and both stakeholders' actions and attitudes are adjusted accordingly.

Understanding TRs therefore requires a model that incorporates all stakeholders, but also an element of process – that is, rather than a TR being a 'state' that is achieved, strong TRs are developed by ongoing and continuous interpretation and adjustment of attitudes and actions by all stakeholders. The model presented builds on previous theories/models of TRs by addressing: the TR as a continual process; both SUs and their clinicians; structural factors that determine the interaction that are unique to community mental health; and finally, the requirement for action from both stakeholders.

When successfully implemented, the JCP intervention facilitated an improvement in TRs by creating a 'new line of action' and demonstrating *Consistent Respect* for SUs. The JCP meeting did not alter the clinicians' view of the TR as there was no evidence from this analysis that the clinicians perceived any change in their interactions or the engagement of SUs. The analysis suggests that the JCP intervention may lead to improvements in TRs for SUs, but these will only be sustained through honouring of the contents of the JCP in crisis or other situations – that is, through consistency of talk and action.

12. Quantitative investigations of Therapeutic Relationships and Joint Crisis Plans

This chapter presents the three quantitative studies of TRs outlined in Section 6.5.3. Using the WAI described in Chapter 6, these studies address the following aspects of Part II objectives:

1. What are the demographic and clinical associations of SU-rated and CC-rated WAI? (Objective 2.1)
2. What is the impact of the Joint Crisis Plan intervention on SU and CC-rated WAI? (Objective 2.2)
3. Can SU and CC-rated WAI at baseline predict clinical and functional outcomes at follow-up? (Objective 2.3)

Supplementary questions (convergence and complementarity investigations) for Objectives 2.1 and 2.2 will also be presented.

12.1. Study One: Statistical associations of Therapeutic Relationships

12.1.1. Introduction

Objective 2.1 (see Section 6.2) was to determine firstly, how individual stakeholders in community mental health view and understand TRs, and secondly to uncover the barriers and facilitators to the development of strong TRs. The examination of statistical associations is an important component of answering the second part of this objective in particular. As illustrated in the systematic reviews in Chapter 3 the current research evidence for associations of TRs is somewhat equivocal. The strongest linkage was with aspects of treatment and medication adherence and social functioning. This analysis extends these findings by examining a wide range of demographic and clinical associations of both SU and clinician-rated TRs in a large sample of individuals with psychotic diagnoses.

12.1.2. Method

The method was described in Section 6.5.3.1. Predictors of the dependent variables (WAI-SU and WAI-CC) are shown in Table 12-1.

Table 12-1: List of predictor variables by category

Demographic	Clinical	Service Provision	Service experience
SU ethnicity	Diagnosis	Length of relationship*	Perceived Coercion*
CC Ethnicity	Self harm	CC Length of Practice	Negative Pressures*
Ethnic Match	Harm to others*	Team type	Procedural Justice*
SU Sex	Suicide*	Number of service contacts*	Sectioning
CC Sex	Functioning	SU engagement*	WAI (by other)
Sex Match			
SU age			
CC age			
Age group match			
SU Qualifications			

Notes:

* Variables indicated in qualitative analysis – ‘threads’

Variables with an asterisk in Table 12-1 are those indicated by the qualitative analyses (i.e., ‘following a thread’). For SUs aspects of consistency (Section 11.2.1), control (Section 8.4) and ‘voice’ (Sections 8.1.2 and 8.2.2) were particularly important. These factors were able to be investigated using the following proxy variables: length of relationship; perceived coercion and procedural justice subscales from the Admission Experience Scale (see Section 6.5.2.2). For clinicians, one of the key categories related to responsibility for managing risk (Sections 9.1.2 and 10.1.1), therefore aspects associated with risk (including suicidality and harm to self and others) were also investigated. Additionally, many clinicians measured the quality of the TR by whether the SU engaged in treatment, therefore, ‘engagement’ was included in these analyses. Similarly, the suggestion of burden found in the CC data (Section 9.3.3.2) was investigated using the number of service contacts. Other aspects suggested by the qualitative analysis including trust, respect, attitudes to care planning, were not able to be investigated in these analyses (see Section 12.1.5.3 on limitations).

12.1.3. Results

12.1.3.1. Description of the sample

The demographic profile of SUs is presented in Table 7-1. Demographic information for the 534 CCs who completed the demographic questionnaire at baseline is shown in Table 7-2.

12.1.3.2. Continuity in relationships

At follow-up, data was collected on the continuity in relationship. Of the 450 SU who had a CC at follow-up and attended a follow-up interview, 5 had missing data on continuity. 233/450 (52%) had the same CC at follow-up. The proportion of SUs with a new clinician at follow-up was lower ($\chi^2(df=2) = 9.58, p = 0.008$) in the London site (38%) than the other two sites (both 53%).

The number of CCs a SU had over the follow-up period was available for 541 SU, and ranged from 1 (i.e., no change) to 8 (median=1, average =1.64 (sd = 0.83)). The mean length of relationship for the total sample was 26.95 months (range 1 to 258.5). For those with a new CC at follow-up, the average length of relationship was 8.97 months.

12.1.3.3. Characteristics of clinicians at follow-up

Since there was an almost 50% change in CCs at follow-up, demographic information for this CC sample at follow-up is presented in Table 12-2. Note the total sample is 450 which was equal to the number of SUs who had a CC at follow-up.

Table 12-2: Demographics of care coordinator sample at follow-up

Variable	Category Value	Birmingham (n= 154)	London (n= 159)	Manc/Lanc (n=137)	Total (n=450)
Sex	Male (n, %)	44 (30.5)	65 (41.1)	52 (38.5)	161 (36.8)
	Female (n, %)	100 (69.4)	93 (58.9)	83 (61.5)	276 (63.16)
Age	N (Mean (sd))	111 (43.3 (9.1))	109 (46.5 (9.23))	129 (41.4 (7.67))	349 (43.6 (8.87))
Ethnicity (grouped)	White (n, %)	95 (69.8)	58 (39.5)	123 (91.8)	276 (66.2)
	Black/Black British (n, %)	17 (12.5)	68 (46.3)	1 (0.75)	86 (20.6)
	Other (n, %)	24 (17.6)	21 (14.3)	10 (7.4)	55 (13.2)
Qualifications	CPN (n, %)	98 (68.1)	93 (58.8)	81 (60.5)	272 (62.4)
	Social worker (n, %)	39 (27.1)	56 (35.4)	49 (36.6)	144 (33.1)
	Other (n, %)	7 (4.8))	9 (5.7)	4 (2.9)	20 (4.6)
Length of relationship (months)	N (Mean (sd))	143 (23.2 (22.5))	156 (33.3 (33.2))	134 (23.6 (21.9))	433 (26.9 (27.05))
Length of practice (months)	N (Mean (sd))	142 (208.4 (187.6))	156 (165.2 (110.5))	134 (127.1 (85.5))	432 (167.6 (138.6))

Abbreviations: CPN: community psychiatric nurse; sd: standard deviation.

12.1.3.4. Missing data and distribution of dependent variables

Detailed description of missing data at baseline and follow-up, and the analysis of associations of missing WAI-SU at follow-up is shown in Appendix V. This analysis indicated that SUs with missing data were more likely to be from the Manchester/Lancashire site and have a higher number of admission in the two years prior to baseline assessment. These variables were therefore controlled for in multivariate analyses.

The distribution and descriptive statistics of the dependent variables are shown in Appendix W.

12.1.3.5. Reliability of the Working Alliance Inventory

The reliability of a scale is the extent to which measures the phenomenon of interest.¹⁶⁰ The internal consistency is the extent to which individual items within a scale relate to the underlying latent variable. Variation in the extent of the relationship of each item to the phenomenon can be attributable to a) the real relationship i.e., the 'signal' and b) the error in measurement or 'noise'.¹⁶⁰ Cronbach's alpha is a commonly used measure of internal

consistency and reports on both the signal and the noise components. Alpha is defined as 'the proportion of a scale's total variance that is attributable to a common source, presumably the true score of a latent variable'¹⁶⁰ (p31), that is the 'signal'.

The internal reliability of the WAI-SU and WAI-CC total scores were 0.93 and 0.88 respectively, suggesting a high degree of internal consistency for both scales. These figures are very similar to the previous analysis²²³ of the modified version of WAI which were discussed briefly in Section 6.5.2.1.

12.1.3.6. Multivariate analyses

Two longitudinal regression models were tested using WAI-SU and WAI-CC as the dependent variables.

Variables associated with service user ratings

Using robust longitudinal regression (see Section 6.5.3.1 – Analysis Plan) all variables were entered into the model. Predictors with a p value of >0.20 were excluded and the regression repeated. Excluded predictors were re-entered into the resulting model and retained if significant. The overall resulting model (Wald $\chi^2(10) = 183.37, <0.001$), adjusted for variables associated with missing data at follow-up (site and previous admissions), accounted for 27% of the variance. Coefficients for variables are shown in Table 12-3: Associations of WAI-SU.

Several demographic variables made it into the final model. SUs' ethnicity (i.e., 'other' groups rating WAI as stronger than White groups), clinicians' ethnicity (Black clinicians rated as creating poorer alliances), and the ethnic match with clinician (matched pairs having stronger alliances) all affect ratings on the WAI. Higher levels of education were associated with weaker alliances. Younger SUs rated their relationships as stronger than older SUs. Interestingly, a secondary analysis showed that the length of contact with mental health services was not significantly associated with ratings on WAI.

In terms of clinical variables, non-affective psychoses and experience of self-harm were associated with weaker alliances. Incidences of suicide

attempts and harm to others, and levels of functioning were not entered into the model.

Table 12-3: Associations of WAI-SU

WAI-SU	Coefficient	Robust Standard Error	P	95% Confidence Interval	
SU ethnic group					
Black cf White SU	-0.97	0.71	0.172	-2.35	0.42
Other cf White SU	-2.18	0.86	0.011	-3.86	-0.49
CC ethnic group					
Black cf White CC	3.56	0.84	0.000	1.92	5.21
Other cf White CC	0.61	0.75	0.421	-0.87	2.08
Ethnic Match	-1.85	0.65	0.004	-3.12	-0.58
SU age group					
31-45 cf <30years	1.74	0.58	0.003	0.58	2.89
45+ cf <30 years	1.20	0.68	0.076	-0.126	2.54
SU education level (high cf low)	1.92	0.65	0.003	0.65	3.19
Diagnosis					
Affective cf non-affective psychosis	1.72	0.58	0.003	0.58	2.87
Self-harm	3.41	0.71	0.000	1.99	4.81
Length of relationship (months)	-0.01	0.01	0.067	-0.032	0.001
Engagement	0.06	0.04	0.108	-0.01	0.15
Perceived coercion	0.88	0.01	0.000	0.61	1.15
WAI-CC	0.33	0.06	0.000	0.21	0.46
Time	1.71	0.48	0.000	0.77	2.65
Trial Arm	-0.82	0.66	0.215	-2.11	0.48
London cf Birmingham	-0.66	0.69	0.337	-2.02	0.69
Manc/Lanc cf Birmingham	-0.38	0.62	0.539	-1.60	0.84
No. admissions (2 years before baseline)	-0.58	0.28	0.042	0.02	1.13

Abbreviations: cf: compared to; CC: care coordinator; SU: service user; WAI-SU: SU-rated Working Alliance Inventory; WAI-CC: CC-rated Working Alliance Inventory.

Notes:

High education=vocational or higher; Low education = none/school based

Intraclass correlation: 0.37;

Tests for categorical predictors: SU age group χ^2 (2)=8.76, $p=0.0125$; SU ethnic group χ^2 (2)=6.58, $p=0.037$; CC ethnic group χ^2 (2)=18.14, $p=0.0001$.

Of the service provision variables, length of relationship and SU engagement made it into the final model, but did not reach significance individually. The length of practice of the CC, team type, and the number of mental health contacts did not make it into the final model.

Two service experience variables (perceived coercion and weaker alliances rated by the clinician) were significantly predictive of weaker WAI-SU ratings. The other variables (negative pressures, voice, sectioning) did not make it into the final model.

Variables associated with care coordinator ratings

Using the same process, individual variables were entered into a robust longitudinal model predicting scores on WAI-CC. The resulting model (Wald $\chi^2(8) = 450.26$, $p=0.0000$) accounted for 44% of the variance. Coefficients of predictors are shown in Table 12-4.

Table 12-4: Associations of WAI-CC

WAI-CC	Coefficient	Robust Standard Error	p	95% Confidence Interval	
SU ethnic group					
Black cf White SU	-0.84	0.40	0.038	-1.63	-0.05
Other cf White SU	-0.88	0.48	0.070	-1.84	0.073
CC Age Group					
31-45 cf < 30 years	1.13	0.53	0.033	0.09	2.16
45+ cf < 30 years	1.47	0.55	0.008	0.38	2.55
Functioning	-0.025	0.01	0.033	-0.05	-0.002
Length of relationship	-0.03	0.005	0.000	-0.04	-0.02
Number of clinical contacts (High vs. Low)	-0.50	0.31	0.104	-1.10	0.10
Engagement	0.40	0.02	0.000	0.36	0.44
WAI-SU	0.13	0.03	0.000	0.08	0.19
Time	0.23	0.38	0.55	-0.51	0.96
Trial Arm	-0.41	0.44	0.344	-1.26	0.44

Abbreviations: cf: compared to; CC: care coordinator; SU: service user; WAI-SU: SU-rated Working Alliance Inventory; WAI-CC: CC-rated Working Alliance Inventory

Notes:

High contacts=more than once a week; Low contacts=once a week or less

Intraclass correlation: 0.20;

Tests for categorical predictors: CC age group $\chi^2(2)=7.07$, $p=0.0291$; SU ethnic group $\chi^2(2)=6.44$, $p=0.0399$.

In terms of demographic variables, older clinicians rated their relationships with SUs as weaker than younger clinicians, and Black SUs were rated by CCs as creating stronger alliances than White SUs. Matching ethnicity, sex, SU age and education level did not make it into the final model.

Of the clinical variables, only functioning as measured by the GAF had a small but significant impact on WAI-CC. Three service provision predictors were significant: longer relationships, better SU engagement and fewer contacts generated stronger alliances. Additionally ratings by SUs were also significantly associated with WAI-CC.

12.1.4. Summary

The aim of this analysis was to determine variables associated with both SU and clinician-rated WAI. Four groups of predictors were examined: demographic, clinical, service provision and service experience variables.

The specific hypotheses tested were:

- 1) Demographic variables would be associated with WAI-SU
- 2) Clinical predictors would be associated with WAI-CC
- 3) Service provision variables would be associated with WAI-CC
- 4) Service experience variables would be associated with WAI-SU
- 5) WAI-CC would be moderately associated with of WAI-SU.

The findings are summarised in Table 12-5.

12.1.4.1. Influence of demographics on WAI-SU

Hypothesis 1 was supported. Ethnicity was a key predictor. For SU ratings, the SU's ethnicity, CC's ethnicity and ethnicity matching were all significantly predictive. As shown in SR2 (see Section 3.2) only one other study has looked at the impact of ethnicity on TRs and found no effect.¹²⁸ In the current study, 'Other' ethnicities (mostly Asian/Asian British) rated alliances with CCs as higher than both Black and White Groups. This may be representative of cultural differences in attitudes to professionals, and/or different ethnic groups' responses to institutions, however this would require further research. The finding that Black CCs were rated more poorly than non-Blacks is interesting. There are a couple of potential explanations for this finding. Firstly, while information was not collected on CC's country of birth, the NHS does rely on many immigrant workers.

Table 12-5: Variables significantly associated with stronger service user and care coordinator rated Therapeutic Relationships

	Demographics				Clinical		Provision		Experience	
Stronger SU-rated WAI is associated with:	SU	CC	Match		Diagnosis	Affective psychosis	Length of relationship	-	Perceived Coercion	Lower Perceived Coercion
Ethnicity	Other	Not Black	Yes		Self-harm	No experience	Length of Practice	-	Negative Pressures	-
Sex	-	-	-		Suicide	-	Team type	-	Procedural Justice	-
Age	Younger	-	-		Harm to others	-	Number of contacts	-	Sectioned	-
SU Qualifications	Lower				Functioning	-	Engagement	-		
Stronger CC Rated WAI is associated with:	SU	CC	Match		Diagnosis		Length of relationship	Longer relationships	Perceived Coercion	-
Ethnicity	Not White	-	-		Self-harm	-	Length of Practice	-	Negative Pressures	-
Sex	-	-	-		Suicide	-	Team type	-	Voice	-
Age	-	Younger	-		Harm to others	-	Number of contacts	Fewer	Sectioned	-
SU Qualifications	-				SU Functioning	Higher	Engagement	Stronger		

Abbreviations: SU: service user; CC: Care coordinator; EI: early intervention team; AOT: assertive outreach team;

In this context it is possible that such immigrant workers may have trained in other countries, have languages other than English as their first language and be new to the NHS model and policies. These differences may affect their ability to build strong TRs with SUs. Secondly, Black CCs may be rated more poorly due to prejudicial attitudes amongst SUs. Matching of ethnicity did improve ratings on WAI for all SUs, suggesting that SUs prefer CCs that they perceive to be similar in background and cultural understanding. This is consistent with previous literature in this area. A recent systematic review²³⁰ found 81 studies that examined appraisals of ethnically matched therapists and found an average effect size of 0.32, suggesting a tendency to appraise matched therapists more highly. Additionally, qualitative research suggests that matching may improve levels of understanding and communication.²³¹

Younger SUs rated their relationships as stronger than older SUs. This is an interesting finding and may be related to willingness to accept intervention. Most previous research has found no effect of age on TRs.^{120-122;128} There was some suggestion in the qualitative analyses for a differential effect according to age, particularly in relation to expectations for MHS (see for example Section 8.4.2), however, this needs further examination.

More highly educated SUs rated their alliances with CCs as weaker. Previous research has found no association with levels of education and TRs,^{121;122} but it has been hypothesised by some that higher education may lead to stronger relationships as it might be easier for clinicians to build relationships with people of a similar intellect as themselves.⁸⁷ In this sample, it is the opposite and suggests that rather the increasing the similarity between clinician and SU, higher levels of education may lead to more critical appraisals of services.

12.1.4.2. Influence of demographics on WAI-CC

SU ethnicity was significantly associated with WAI-CC, with White SUs rated more poorly by CCs than other ethnic groups. This is similar to the finding regarding 'Other' ethnicities and improved WAI-SU described above. Ethnic matching did not affect the ratings of CCs. As for WAI-SU, age was

associated with ratings on WAI-CC, with older CCs rating TRs more poorly than younger CCs. Like SUs ratings it does not appear to be a result of length of time in MHS (as CC length of service did not make it into the final model). Rather, this may indicate decreasing morale or confidence in ability to help SUs with long-term conditions which increases with CC age. No studies examining the effect of CC demographics on their own ratings were found for SR2 (see Section 3.2). Other investigations in this area have tended to focus on issues about morale and burnout and examining associations with bureaucracy.^{232;233} These findings suggest that the demographics of CCs themselves, in addition to those of the SUs, may be an important influence on CCs' perceptions of TRs.

12.1.4.3. Influence of clinical variables on WAI-SU

SU ratings were predicted by two clinical variables: experience of self-harm and diagnostic group. Self-harm was associated with poorer ratings on WAI. The relationship between self-harm and TRs has not been tested in a psychosis sample (see Chapter 3). As self-harm is often associated with personality disorder, and comorbid diagnoses were not a reason for exclusion in the trial, it is possible that SUs' ratings may have been affected by such traits.²³⁴ Core diagnoses did affect WAI-SU, with SUs with non-affective psychoses rating their alliances as weaker than those with affective psychosis. This is contrary to the literature found in SR2, where the two studies that investigated diagnosis, found no effect^{121;128} and the evidence for an association with mood and anxiety^{120;121;126} levels was equivocal. One potential explanation is the differences in time and sample size between this analysis and those previously published. This analysis is effectively an average of two cross-sectional analyses and therefore had a very large sample size (approximately 1000 subjects). Previous studies have examined temporal associations and with much smaller samples. Non-affective psychoses, such as schizophrenia, are generally considered to have a worse prognosis than affective disorders such as bipolar. The poorer ratings may be reflective of the non-affective group feeling that they were unable to be helped by clinicians. This is consistent with recent research in Australia that found weaker alliance scores for individuals with schizophrenia that was associated with recovery progress.²³⁵ Additionally, aspects specific to non-

affective psychosis such as paranoia, may make developing TRs more difficult with this group. This latter explanation is in keeping with some reports of clinician attitudes regarding developing TRs with individuals with psychotic disorders.⁹³ In this context, aspects of trust and hope may be integral to the TR and are partially supported by the qualitative analyses (see Section 11.2.4) and represent an interesting avenue for further research.

12.1.4.4. Influence of clinical variables on WAI-CC

Hypothesis 2 was supported. The only clinical variable that made it into the model of WAI-CC was functioning. Higher functioning was associated with stronger WAI-CC. This makes intuitive sense, for example, SUs who function at a higher level could be easier to interact with, may be less reliant on clinicians, and may respond more to treatment efforts – creating an impression that the CC is helping them. This supports the qualitative data finding regarding establishing common ground and proving worth for both CCs and psychiatrists (see Sections 9.3 and 10.2). Additionally, this is consistent with previous literature found in SR1 and SR2, showing a link between clinician ratings and functioning.^{104;105;121;132} In contrast to the suggestion from the qualitative data, variables measuring risk such as suicide attempts, harm to self and others, did not make it into the final model. This perhaps suggests that the feelings of ‘responsibility and accountability’ are generalised and not related specific to individual’s risk profiles. This is consistent with a recent audit of care plans¹⁷⁸ which found no relationship between the specificity of the care plan and the risk profile of the individual concerned. However, as these are exploratory analyses, this would need to be corroborated in other studies.

12.1.4.5. Influence of service provision

Hypothesis 3 was supported. Stronger WAI-CC was associated with three service provision variables: longer relationships, fewer service contacts and better engagement from the SU. The finding that longer relationships are linked with stronger TRs suggests that clinicians take a long term view when building relationships with SUs, as indicated by needing to prove their worth and build trust over time (see Section 10.2). This is inconsistent with the one previous study that has examined such an association which found longer relationships decreased the TR, however, this was with vocational workers and may be indicative of the time-limited nature of their intervention.¹²¹

The association between fewer service contacts and stronger TRs is also consistent with the findings of one other study that investigated this association.¹²⁸ Qualitative data regarding 'involving others' (see Section 9.3.3.2) suggested that some CCs felt burdened by the relationship with SUs. In this context, fewer contacts would be associated with an improved perception of the TR. Additionally, fewer contacts would most likely be an indication of lesser need; itself an indication that the clinician is helping the SU (see Sections 9.3, 10.2.1, and 4.3.3).

The association between better levels of engagement and stronger TRs is in keeping the findings from the CIS regarding 'engagement as the goal' (see Section 4.3.1.1) and also previous research presented in Chapter 3 regarding the link between TRs and adherence.

SU ratings were not significantly associated with the service provision variables in this analysis. It is perhaps surprising that the length of relationship with a CC did not make it into the model as this is often cited in the literature as a key preference for SUs and an important part of service delivery,² however, the only previous study found in SR2 which examined this found no association.¹²¹ Again, as these are exploratory analyses, these results need corroboration.

12.1.4.6. Influence of service experience

Hypothesis 4 was supported. SU ratings were associated with feelings of coercion. Recent research in this area has linked TRs to experience of coercion.¹²³ It was surprising that the experience of being sectioned did not make it into the model of WAI-SU. Negative past experiences (often related to hospitalisations and sectioning) was a key category in the qualitative data (see Section 8.1). Similarly, the 'procedural justice' subscale also did not make it to the final model. This subscale captures the extent to which the SU felt listened to during their experiences in the community and therefore it was considered a proxy measure of categories from the SU data including '*Being heard*' and '*Controlling my story*' (see Sections 8.1.2 and 8.2.2). The procedural justice subscale comprises only three items and so perhaps individually it was not sufficiently robust to make it into the model over and above that of the 'perceived coercion' subscale which covers aspects of control.

WAI-CC was not associated with service experience variables.

12.1.4.7. Influence of WAI ratings

Hypothesis 5 was also supported. WAI-SU was associated with WAI-CC. However the association between these variables was comparatively small resulting in a less than one point change in ratings. This is consistent with previous research^{121;122;128} which has found small to moderate associations between the two ratings. As suggested in Section 3.3.3.2, the small associations may be indicative of different latent variables captured by the ratings. Qualitative data presented in the preceding chapters suggest some commonalities between SUs' and clinicians' appraisals of TRs (such as a 'person-centred' approach), however, there was also an indication of differences such as clinicians appraisals of SU engagement, compared to SUs' appraisals of interactional outcomes (see Section 11.2.2). Furthermore, the differences in associations found in this analysis (see Table 12-5: Variables significantly associated with stronger service user and care coordinator rated Therapeutic Relationships) provide some preliminary

evidence for the proposal of a different latent variable assessed by the two ratings.

12.1.5. Complementarity and convergence investigations

This comparatively large sample size provides some important insights into TRs in community mental health. These findings will be discussed in terms of 'complementarity' and 'convergence' investigations. For convenience, the relevant section of Table 6-2 is repeated below.

Repeat Objective 2.1 Section of Table 6-2

Objective	Priority Method	Secondary Method	Convergence/ Complementarity
How do key stakeholders view and understand TRs in community mental health settings and what are the barriers and facilitators to the development of strong TR?	QUALITATIVE	Quantitative	<ol style="list-style-type: none"> 1. Complementarity: demographics and clinical variables not emerging from qualitative investigated for statistical associations with ratings of TR 2. Convergence: Categories from qualitative data, tested statistically, e.g., interactional components from qualitative such as 'control' investigated by testing the statistical association of 'perceived coercion' with ratings of TR.

12.1.5.1. Following the threads: convergence investigations

Convergence 'threads' suggested from the qualitative analysis included clinical, service provision and experience variables. One of the key categories in the SU qualitative data was '*Being in control of my experience*', which was related to '*Agency*' in the model of *Consistent Respect* presented in Section 11.2. The finding from this analysis that '*Perceived Coercion*' was significantly associated with TRs is consistent with these qualitative threads, suggesting that this is a key facet of the TR for SUs and is supported by literature in this area (see Section 3.2.3.5 - Service delivery, use and adherence). In this context, interventions and treatment models that seek to build autonomy and involvement of SUs should be emphasised. Other 'threads' from the qualitative data were not supported in this analysis. For example, the length of the relationship between the CC and SU was considered a proxy measure of '*Consistency*', however, this did

not make it into the model. The length of relationship may not have been a strong proxy measure of consistency, particularly as it does not capture aspects about consistency between 'talk and action'.

For clinicians, several convergence threads were examined. In particular, aspects associated with risk (suicide, harm to self and others) were hypothesised to be associated with the qualitative categories relating to responsibility and accountability. This was not supported, and as discussed above, is suggestive of a generalised perception of risk not associated with individuals. Service provision variables in the final model provide evidence for aspects associated with TRs reported by clinicians in the qualitative data, in particular 'engagement' and service contacts. These findings indicate that for clinicians strong TRs are related to aspects that suggest they are performing well in their role, that is SUs are engaged, but functioning highly and requiring lesser input.

12.1.5.2. Complementarity investigations

Complementarity investigations (i.e., those not emerging from the qualitative analyses) add further depth to the understanding of TRs. Such analyses suggest that stronger SU-rated TRs are associated with being young, lower levels of education, feeling similar to your CC, and having an affective psychosis diagnosis. It is possible that younger SUs, with lower levels of education, and affective psychoses may be more optimistic of being helped by clinicians and thus rate their TR as stronger. This finding is consistent with the category of '*Clinicians doing their job*' (Section 8.2.3), and in particular the aspects of that category relating to the assessments of clinicians' ability and demonstration of help and support.

The findings regarding the impact of ethnicity suggest that feeling similar to a clinician may improve the TR, and is consistent with the qualitative data about '*Being known*' (Section 8.2.1) and in particular aspects that cover being understood. CCs from different ethnic backgrounds to the SU may therefore need to make extra efforts in finding aspects of common ground or experience in order to build stronger relationships.

The impact of CC age on their own ratings of the TR suggests that older clinicians may need further support and clinical supervision to guard against drops in morale. This finding, in addition to those relating to age, education and diagnosis of SU discussed above, and indeed the qualitative data suggest that 'hopefulness' may be an interesting avenue for further research into the TR.

12.1.5.3. Limitations and strengths

Several potentially important associations were not investigated in this analysis which is indicative of the limitations of embedding a mixed methods approach into a large scale, multi-site trial with tight deadlines. Ideally, several variables indicated by the qualitative analysis would have been measured quantitatively to provide convergence, however, the qualitative data collection and analysis occurred towards the later stages of the trial at which point it was too late to make amendments to the protocol. Key aspects indicated in the qualitative analysis such as trust, respect and role definition and identity were not able to be investigated. Such variables present an interesting avenue for future research. Furthermore, the finding that youth was associated with both WAI-SU and WAI-CC would ideally have been investigated in the qualitative work by asking some questions about the importance of hope.

It should be noted that the analyses do not provide evidence of no association between the TR and variables not included in the model. Rather, variables may have weak associations that were not sufficiently powerful to make it into the model.

There were two particular strengths to this analysis. Firstly, the longitudinal multivariate approach was able to control for potential confounders such as time and thus provides a robust and rigorous analysis of the associations of TRs within a large sample of individuals with psychosis. Secondly, 'following threads' from the qualitative data provides a richness to the interpretation of the results.

12.2. Study Two: Impact of Joint Crisis Plans on ratings of Therapeutic Relationships at follow-up

Objective 2.2 was to determine if the JCP intervention affected the TR and to explain the mechanism underlying the effect. This section of the chapter describes the investigations in Study 2, and has three main parts:

- Quantitative analyses used to address the primary question of 'Do JCPs affect the TR?'
- Secondary quantitative analyses (point 3 in the repeated section of Table 6-2 below) which adjusted for elements hypothesised to represent the mechanism of the JCP's effect.
- Discussion of the convergence and complementarity investigations (points 1, 2 and 3 in the repeated section of Table 6-2 below).

Repeat of Objective 2.2 in Table 6-2

Objective	Priority Method	Secondary Method	Convergence/ Complementarity
Do JCPs affect TRs and if so, how?	QUANTITATIVE	Qualitative	1. Convergence: reports of effect of JCP 2. Complementarity: mechanism of effect in qualitative 3. Convergence: elements of effect controlled for in secondary quantitative analyses

12.2.1. Background

The CPA is a centre point of the government's mental health strategy in England. As discussed in Chapter 2, the key components of the CPA are assessment, an agreed care plan and regular reviews of SU needs. An individual's CPA care plan should contain a history, current treatment plan and a section detailing a response to a crisis or relapse – the crisis and contingency plan. The guidelines for the CPA care planning stipulate that this process should involve the SU. However, as discussed in Section 2.3.4.2, implementation and involvement of SUs has been inconsistent. Research suggests that the content may be decided without the SU and that SUs may not be aware of their care plan nor feel able to freely communicate

their concerns and wishes,^{59;60} and the content may be formulaic rather than individualised.¹⁷⁸

In contrast, the JCP intervention, as discussed in Section 5.4, was designed to ensure the free expression of SU views regarding past and future treatment. The JCP Facilitator aims ensure everyone's views are expressed and considered, and decisions are freely agreed. The deliberate seeking of the SU's views before those of the clinicians, and the wording of the JCP in the first person, was stipulated to empower the SU and ensure they felt listened to and acknowledged. It was hypothesised that this enabling of free expression may be a point of contrast with previous planning sessions where the content is usually directed by the clinical team; there was some support for this proposition in the qualitative data (see Section 8.2.2).

In this way, it was anticipated that the process of discussing the contents of the JCP would lead to general improvements in the TR. Previous research by the JCP team and researchers of other similar interventions suggested that this may indeed be the case (see Section 5.5). This analysis aimed to determine whether the JCP intervention improved scores on the WAI and whether this effect was sustained after an 18 month period.

12.2.2. Method

The method used for this second study is described in 6.5.3.2.

12.2.3. Results

12.2.3.1. Impact of JCP on WAI-SU (Hypothesis 1)

There was some weak evidence for an effect of the JCP intervention on WAI-SU in an unadjusted model (16.0 (7.1) v 17.3 (7.6) unadjusted difference -1.29 (95CI - 2.67 to 0.08, $p=0.065$)). However, after planned adjustments, the model suggests that SUs in the intervention group had significantly stronger TRs (i.e., lower scores) than those who did not (adjusted difference -1.33 95% CI -2.59 to -0.07, $p=0.038$). The final model ($F(5, 437) = 16.23$, $p=0.0000$) accounted for 18% of the variance. Individual coefficients in the model are shown in Table 12-6.

Table 12-6: Impact of Joint Crisis Plan intervention on WAI-SU

WAI-SU	Coefficient	Robust Standard Error	p	95% Confidence Interval	
Trial Arm	-1.33	0.64	0.038	-2.59	-0.07
WAI-SU (Baseline)	0.46	0.06	0.000	0.35	0.58
London cf Birmingham	0.47	0.79	0.549	-1.08	2.03
Manc/Lanc cf Birmingham	-1.09	0.81	0.175	-2.69	0.49
Number of admissions in 2 years before baseline	-0.01	0.41	0.975	-0.83	0.80

Abbreviations: Manc/Lanc: Manchester/Lancashire site; cf: compared to; WAI-SU: SU rated Working Alliance Inventory.

12.2.3.2. Impact of Joint Crisis Plan on WAI-CC (Hypotheses 2 and 3)

Following the same methodology as above, Trial Arm was regressed on WAI-CC. The unadjusted model suggested there was no effect of the intervention on WAI-CC (17.5 (5.10) v 17.06 (5.2) unadjusted difference - 0.43 (95CI -1.40 to 0.53, $p=0.375$)). Similarly, the planned adjustments had no overall effect (adjusted difference -0.33, 95CI -1.24 to 0.58, $p=0.473$). Individual coefficients for the predictors are shown in Table 12-7.

Table 12-7: Impact of Joint Crisis Plan intervention on WAI-CC at follow-up

WAI-CC	Coefficient	Robust Standard Error	p	95% Confidence Interval	
Trial Arm	-0.33	0.463	0.473	-1.24	0.58
WAI-CC (Baseline)	0.44	0.049	0.000	0.33	0.53
London cf Birmingham	-0.59	0.552	0.289	-1.67	0.498
Manc/Lanc cf Birmingham	-0.48	0.571	0.424	-1.58	0.666

Abbreviations: Manc/Lanc: Manchester/Lancashire site; cf: compared to; WAI-CC: CC rated Working Alliance Inventory.

Predicting ratings of the WAI-CC by trial arm, did not establish whether the exposure of the clinician *themselves* to the JCP had any significant effect on their WAI ratings. However, adjusting for the effect of CC exposure

(defined as whether the CC was same at follow-up and whether they attended the JCP meeting) did not significantly affect the WAI-CC (adjusted difference= -0.47, 95CI:-2.44 to 1.50, p=0.638).

12.2.3.3. Adjusting for 'Consistency' on effect of JCP on WAI-SU (Hypothesis 4)

Two aspects of 'consistency' were investigated: clinician turnover and non-attendance at the JCP meeting. After adjustments for clinician turnover (i.e., adding length of relationship), there was a change in the Trial Arm coefficient (-1.19, 95CI -2.48 to -0.09, p= 0.070). This suggests that clinician turnover may be an important determinant of the effect of the intervention for SUs.

As reported in Section 7.2.4, 67% of JCP planning meetings had the full normal clinical team present. The presence of the clinical team during the meeting provided some indication of their commitment to the JCP intervention and their reliability and consistency in honouring commitments to SUs. A variable called 'Full normal team' was created with three groups: JCP with full normal team; JCP without full team; and Control. 'Full normal team' was then added to the final model. There was a marked change in the coefficient of Trial Arm (0.266, 95CI -2.31 to 2.84, p= 0.840) after this adjustment suggesting that improvements generated in WAI-SU from the JCP were ameliorated if the full clinical team was not present during the meeting.

12.2.4. Summary

This study was designed to answer Objective 2.2 of this thesis, i.e., to determine the impact of the JCP intervention on ratings of WAI. All four hypotheses were supported. Firstly, SUs who were allocated to the JCP intervention had stronger TRs than the control group participants. Secondly, the JCP intervention had no effect on the TRs rated by CCs. Thirdly, adjusting for CC exposure to the intervention did not affect the relationship between the JCP and ratings on WAI-CC. Finally, the effect of the JCP intervention on WAI-SU was lost after adjusting for clinician discontinuity and non-attendance at the meeting.

The initial improvements seen in WAI-SU after the JCP intervention is consistent with the previous research in this area such as the study of F-PADs in the US that found an effect on WAI at one month follow-up¹³⁵ and qualitative findings of an improvement.^{180;186} These analyses suggest that the effect of such processes may be sustained over a much longer period. The lack of effect for CC ratings is also consistent with previous research.^{185;186;190}

The exposure of an individual SU to the intervention did not improve the TR as rated by their clinicians. In other words, the JCP did not significantly alter the overt behaviour of the SU from the perspective of the clinician. As there is no previous research regarding the impact of such interventions on clinician ratings, the hypothesis was that it would have no effect. However, it is feasible, that had the intervention had a dramatic effect on the SU's behaviour (such as improvement in communication or help-seeking) then the clinician ratings would reflect this. However, this appears not to be the case.

12.2.4.1. Convergence and Complementarity investigations

Convergence of quantitative findings with qualitative reports on effect of JCP

The two main findings regarding the impact of the JCP on WAI-SU and WAI-CC converge with the qualitative analysis. For SUs, firstly the independent Facilitator ensured that their perspectives were heard and secondly, they had some assurance that their treatment wishes would be honoured (e.g., see '*Consistent Respect*', '*Being known*', '*Holding clinicians to account*'). Secondly, clinicians reported that while the JCP may have had a positive effect for SUs, it did not affect their appraisal of the TR primarily as it did not affect the SU's engagement (e.g., '*Not benefitting me*').

Based on the two perspectives, it is possible to conclude that the JCP may positively affect the TR from the perspective of SUs, but not from clinicians.

Mechanism of effect of JCPs on the TR (Points 2 and 3: complementarity and convergence findings)

As outlined in Section 11.3, the JCP could be a 'new line of action' which promoted the demonstration of '*Consistent Respect*'. The assessment of '*Consistent Respect*' required consistency in honouring commitments and between talk and action. Adjusting for proxy measures of 'consistency' provides further evidence for the mechanism proposed. The beneficial effects of the JCP were not found in situations where there was turnover of clinicians or where the full normal team was not present. In both of these scenarios, the model presented in Section 11.2 suggests that SUs would interpret this as demonstrating a lack of commitment to them and to the JCP, thus undermining its effect.

Continuity of clinician is often cited as an important indicator of quality service provision² however, as discussed in Section 12.1.4.5, there is no empirical evidence for its effect on the TR. In the analyses presented in this chapter, length of relationship (a measure of continuity) did affect the impact of the JCP, but did not make it into the final model of WAI-SU from Study 1 (see Table 12-3: Associations of WAI-SU). This suggests that continuity of clinicians was particularly important in the context of the JCP as it was appraised by SUs as indicative of the clinicians' commitment to them, but also the JCP process. This is further supported by the results of adjusting for the attendees at the JCP meeting. In situations where the full clinical team was not present, the beneficial effects of the JCP were not found. The emerging model of the JCP suggests that SUs appraised non-attendance as indicating a lack of respect for them.

Similarly, using the model presented in Section 11.2, the lack of impact on clinicians' ratings of the TR, suggests that the JCP intervention did not sufficiently alter their practice or the behaviour of SUs (i.e., a new line of action). Clinicians, for example, reported that some SUs did not honour the content of the JCPs – something the clinicians may have interpreted as a lack of respect for them (discussed further in Section 13.2.1).

12.2.4.2. Limitations and strengths

Several limitations in these analyses should be acknowledged. Firstly, it was not possible to accurately measure aspects of the implementation of the JCP for every SU. Considering the findings presented, it is likely that the implementation of the JCP (i.e., a demonstration of '*Consistent Respect*') would improve SUs' views of the TR. Secondly, SUs' adherence to the contents of the JCP was also not assessed. Finally, the clinicians' views on the JCP intervention and meeting were not assessed either before implementation or directly after the meeting if they attended. The measures used in the secondary analyses are therefore only a proxy measure of their attitudes to the JCP. Qualitative data suggest that such attitudes may be fundamental to the effect of the intervention. It would be helpful in future trials to collect data on clinician attitudes before and after the JCP meeting. The strengths of this analysis should also be acknowledged. It is a large sample of SUs and clinicians from both metropolitan and rural areas in the UK. Additionally, the use of limited exclusion criteria maximise the chances of these findings closely approximating routine care. The use of mixed methods provides richness to the data and explanations for effect.

12.2.4.3. Conclusions

The JCP intervention improved SUs' views of their TRs with clinicians, however, only when they appraised the clinicians as valuing the process as indicated by attendance at meetings and not subsequently leaving their job. The JCP did not however, affect clinicians' views of the TR. These findings, and those of the qualitative analyses, suggest that the improvement reflects a subtle realignment of the SUs' sense of self, and their trust and attitudes towards MHS, rather than affecting overt behaviours.

The implications of these findings are important. The results suggest several problems with current practice of routine care planning. There is some evidence in these analyses (in particular the qualitative data) to suggest that neither clinicians nor SUs value the process. Routine care planning also promotes ritualised interactions where SUs do not feel listened to or respected as individuals. The JCP intervention appears to have altered such routine interactions with measurable and beneficial effects for SUs.

However, the effects of the JCP intervention were only sustained if the clinicians were engaged with the process. Many clinicians in this trial exhibited a lack of commitment to the JCP through non-attendance, a lack of participation and/or not honouring the plans in a crisis/relapse situation. Such deficits in the implementation of the JCP intervention suggest that more deliberate strategies to engage clinicians needed to be employed. This is discussed further in the final chapter in Section 13.4.

12.3. Study Three: Relationship of WAI to outcomes at follow-up

The third section of this chapter addresses Objective 2.3 of this thesis: that is whether the TR is related to outcomes. The investigation used an exclusively quantitative approach.

12.3.1. Background

As detailed in Chapter 3, the current research evidence for links between TRs and outcomes for individuals with psychotic disorders is largely equivocal. One possible explanation for the lack of clear evidence is the methodology of published studies. Many studies have had small samples, used cross sectional designs, different raters and different time points for measuring outcome, and have not consider the potential effects of confounding variables. A recent review¹¹⁵ came to similar conclusions, however, through statistical techniques determined that there is a stronger likelihood of finding a significant association, than a non-significant association between TRs and outcomes. The authors suggested that the evidence base would be improved by well designed research that measures the TR at baseline and uses validated measures for both TRs and outcome measures. In this context, the current study aims to extend current research by examining the utility of TRs, measured at baseline, in predicting outcome at 18 months whilst controlling for potential confounding variables.

12.3.2. Method

This study used baseline ratings on WAI (both WAI-SU and WAI-CC) to predict outcomes at follow-up (see Section 6.5.3.3).

12.3.2.1. Outcomes examined

The following outcomes at follow-up were examined:

- Psychiatric admissions from patient records.
- The use of sectioning in psychiatric admissions from patient records.
- CC-rated engagement.
- SU-rated perceived coercion.
- SU-reported self-harm, suicide attempts and harm to others.
- Functioning rated by masked RAs using the GAF.

12.3.3. Results

12.3.3.1. Predicting outcome at follow-up with baseline WAI-SU

Poorer baseline values (i.e., higher scores) on WAI-SU were predictive of whether SUs: were sectioned under the MHA; were admitted overall (either under section or voluntarily); harmed themselves; or made suicide attempts over the follow-up period (see Table 12-8). These findings were sustained after adjusting for the influence of the trial intervention, site, ethnicity and baseline values on the outcomes and demographic associations with the WAI (from Study One).

Table 12-8: Predictive utility of baseline WAI-SU

Outcome	N	Coefficient/ Odds Ratio of WAI-SU	P	95% Confidence Intervals	
Sectioned (1)	543	1.04*	0.007	1.01	1.09
Sectioned (2)	492	1.02*	0.017	0.98	1.07
Admitted (1)	544	1.03*	0.030	1.00	1.06
Admitted (2)	492	1.02*	0.014	0.98	1.05
Engagement (1)	360	0.01	0.876	-0.09	0.11
Engagement (2)	346	0.015	0.764	-0.088	0.12
Perceived Coercion (1)	457	0.029	0.085	-0.004	0.063
Perceived Coercion (2)	377	0.006	0.659	-0.021	0.034
Self-harm (1)	501	1.07*	0.013	1.01	1.13
Self-harm (2)	455	1.04*	0.009	0.96	1.12
Suicide attempts (1)	501	1.05*	0.049	1.00	1.10
Suicide attempts (2)	455	1.06*	0.015	0.99	1.13
Harm to others (1)	501	1.02*	0.490	0.962	1.08
Harm to others (2)	455	0.98*	0.636	0.89	1.07
Functioning (1)	501	-0.014	0.834	-0.144	0.117
Functioning (2)	411	0.011	0.889	-0.14	0.170

Notes:

(1) Adjusting for Site, baseline values on outcome and Trial Arm;

(2) Adjusting for Site, baseline values on outcome and Trial Arm, and predictors of WAI-SU (cc ethnicity, ethnic matching, SU education level, diagnostic group)

* Results of logistic regression. Figures are Odds Ratios.

12.3.3.2. Predicting outcome at follow-up with baseline WAI-CC

Poor alliances at baseline, as rated by the CC, were associated with the SU being sectioned under the Mental Health Act, admissions to hospital and incidences of harm to others over the follow-up period. Additionally, poorer alliances were predictive of poorer overall functioning over the follow-up period (see Table 12-9). These findings were sustained after adjustments.

Table 12-9: Predictive utility of baseline WAI-CC

Outcome	N	Coefficient/ Odds Ratio of WAI-CC	p	95% Confidence Intervals	
Sectioned (1)	509	1.07*	0.003	1.02	1.12
Sectioned (2)	431	1.10*	0.000	1.05	1.16
Admitted (1)	509	1.06*	0.002	1.022	1.106
Admitted (2)	431	1.07*	0.004	1.02	1.11
Engagement (1)	362	0.121	0.139	-0.039	0.281
Engagement (2)	304	0.154	0.103	-0.031	0.334
Perceived Coercion (1)	392	0.026	0.094	-0.004	0.057
Perceived Coercion (2)	316	-0.017	0.774	-0.134	0.100
Self-harm (1)	470	1.04*	0.349	0.96	1.12
Self-harm (2)	400	1.03*	0.438	0.95	1.12
Suicide attempts (1)	470	1.06*	0.088	0.99	1.14
Suicide attempts (2)	400	1.06*	0.137	0.98	1.14
Harm to others (1)	469	1.138*	0.003	1.04	1.24
Harm to others (2)	400	1.10*	0.045	1.00	1.21
Functioning (1)	470	-0.280	0.005	-0.475	-0.085
Functioning (2)	400	-0.287	0.009	-0.502	-0.0713

Notes:

(1) Adjusting for Site, ethnicity, baseline values on outcome and Trial Arm

(2) Adjusting for Site, ethnicity, baseline values on outcome and predictors of WAI-CC (CC age group, SU ethnicity)

* Results of logistic regression. Figures are Odds Ratios.

12.3.4. Summary

This study aimed to establish the utility of WAI ratings at baseline to predict outcome over an 18 month follow-up period. Findings supported several hypotheses: poorer WAI-SU was predictive of hospitalisation (Hypothesis 1.1), sectioning (Hypothesis 1.2), having experience of self-harm (hypothesis 1.4) and suicide attempts (Hypothesis 1.5). Similarly, several hypotheses regarding WAI-CC were supported: hospitalisation (2.1), sectioning (2.2), and overall functioning (2.4) were predicted by poorer baseline WAI-CC ratings. WAI-CC also predicted incidences of harm to others over the follow-up period.

These findings are largely consistent with previous research. The literature described in SR1 indicated that overall functioning is not predicted by SU

ratings on measures of TRs^{101;105;107;112} but may be predicted by clinician ratings.¹⁰⁵ The findings regarding hospitalisation have been less consistent but have used different measures of TRs and different metrics of hospitalisation.^{101;102;108;110} Other outcomes (harm to self and others) addressed in this study have not been investigated in the literature in a psychosis sample.

In terms of the previous research discussed above, there have been few attempts to adjust for confounders. For example, Fakhoury and colleagues¹¹⁰ adjusted for previously found associations with the outcome of hospitalisation and included previous hospitalisations and factors such as clinician burnout. They found that for newly established SUs, TRs were predictive, but not for more established SUs; the latter of which is more reflective of the current study population. These findings suggest that the predictive effect of TRs may be dependent on the sample.

In summary, these findings suggest that interventions that improve TRs may lead to a decrease in adverse outcomes such as harm to self and others and hospitalisation.

12.4. Chapter summary

This chapter presented three studies designed to address the three objectives of Part II of this thesis. The three sections of this chapter addressed:

1. What are the demographic and clinical associations of SU-rated and clinician-rated WAI? (Objective 2.1)
2. What is the impact of the Joint Crisis Plan intervention on SU and clinician-rated WAI? (Objective 2.2)
3. Can SU and clinician-rated WAI at baseline predict clinical and functional outcomes at follow-up? (Objective 2.3)

For Objective 2.1, a range of statistical associations indicated by the literature and qualitative analyses in this thesis, were examined for SU and clinician-rated WAI. Stronger TRs, as rated by SUs, were associated with lower SU qualifications, younger age, ethnicity of the CC, affective

psychosis, no experience of self-harm and lower perceived coercion. Stronger CC ratings were associated with non-White SUs, being younger, higher functioning SUs, fewer service contacts, better SU engagement and longer relationships with SUs.

For Objective 2.2, the JCP intervention was used to predict SU and clinician ratings on WAI. The JCP led to improvements in SU but not clinician-rated TRs. Statistical adjustments indicated by the qualitative analyses, provided further evidence for the model of TRs presented in Section 11.2 and suggest that firstly, it is primarily the process of developing the plan which leads to the effect, and secondly, poor clinician engagement in the process of the intervention will undermine this effect.

For Objective 2.3, baseline values of SU and clinician-rated WAI were used to predict outcomes at 18 months. Poorer baseline SU ratings of WAI predicted both being hospitalised and sectioned, and incidences of self-harm and suicide attempts. Poorer clinician ratings of WAI at baseline predicted hospitalisations, sectioning, incidences of harm to others and poorer functioning. All models held after adjusting for potential confounders.

In summary, strong TRs rated by both CCs and SUs may be a protective factor against adverse outcomes. With full engagement of clinicians, the JCP intervention provides a structured protocol that improves SUs' appraisals of the TR, and therefore may protect against negative outcomes.

The implications of these findings are discussed further in the final chapter.

13. Discussion and conclusions

In this last chapter of the thesis, the main results will be summarised and then discussed in terms of implications for research, policy and practice.

There are four main sections to this final chapter:

- A summary of results in relation to each stated objective.
- Key themes arising from the thesis with a particular emphasis on the unique findings.
- A summary of strengths and weaknesses of the thesis.
- Implications for policy, practice and research.

13.1. Summary of findings

13.1.1. Part I: Historical summary of Therapeutic Relationships and current evidence base

In Part I, the aim was to understand how TRs have been described and understood historically. The specific objectives were to:

- 1.1. Describe the historical developments of the concept of TRs in treatment and policy.
- 1.2. Determine the current level of evidence for an association between TRs and other variables including outcomes.
- 1.3. Analyse current understanding and assumptions in literature regarding the barriers and facilitators to TRs.

13.1.1.1. Historical developments in Therapeutic Relationships

The first objective was addressed by the narrative summary in Chapter 2. Covering the major developments in TRs and policies from 18th Century to the present day, this summary indicated that the definition and focus on TRs has fluctuated over time, but is currently emphasised in policy and guidance documents in England for the treatment of individuals with psychotic disorders. The relatively recent focus has meant that in the decades of delivering care in the community, the types of interactions

indicative of a strong TR have not been well defined. While some of the ideology of psychological models of TRs may be applicable to community mental health treatment, there are contextual issues in the community that are not captured by such models. In this context, the analysis in Chapter 2 concluded that a clear model of TRs, that considers contextual barriers and facilitators, was needed.

13.1.1.2. Evidence base for Therapeutic Relationships in community mental health

The second objective was to determine the current level of evidence for the association between TRs and other variables including outcomes. Chapter 3 presented two systematic reviews of the quantitative literature linking TRs for individuals with psychotic disorders with outcomes and other demographic and clinical variables. All studies were observational or secondary analyses of trials. Many had comparatively small samples sizes, and few used multivariate analyses to control for potential confounders. Other methodological concerns included inconsistencies in measurement, timing of assessment, treatment contexts, and raters of the TR. The first review examined outcomes and identified 13 studies. Perhaps a result of methodological issues outlined above, and consistent with a recently published review,¹¹⁵ the evidence linking TRs with outcomes was equivocal. The strongest evidence was for a link between TRs and treatment adherence, however, the effect sizes were small to moderate and the timeframes short to medium. The second review investigated demographic, clinical and functional associations and found 17 studies. The results indicated very little evidence for an association between TRs and demographic and clinical variables. The strongest evidence was a link with service use and treatment adherence. In summary, the two systematic reviews indicated a lack of evidence for the clinical utility of the TR.

13.1.1.3. Current understanding of Therapeutic Relationships in the literature

The final objective of Part I of this thesis was to analyse the current understanding and assumptions in the literature regarding the barriers and facilitators to TRs. Using a qualitative synthesis method called 'Critical

Interpretive Synthesis' (CIS), thirteen papers were reviewed. The analysis suggested a number of factors external to the interactions of individuals which have an impact on TRs. In particular, the CIS suggested an ambiguity of purpose (defined as *Goal Ambiguity*) in community MHS which resulted in role conflict for clinicians. This was consistent with the narrative review presented in Chapter 2 that found no comprehensive model for the TR in community mental health settings. Such contextual problems generated variation in the experience of TRs, and conflicting needs between SUs and clinicians. The CIS suggested the TR was characterised by three main factors: (dis)trust, (dis)respect and (dis)empowerment. These findings were further supported by the qualitative analysis in Part II of this thesis and suggest that such issues are still pertinent today.

Table 13-1 provides a high level summary of the results of Part I.

Table 13-1: Summary of findings in Part I

Objective		Methodology	Key Findings
1	Describe the historical developments of the concept of TRs in treatment and policy	Narrative summary of practice, policies and models from 18 th Century to present day	<ul style="list-style-type: none"> - The emphasis on TRs has fluctuated depending on policy, technology and attitudes. - Current policy and guidelines emphasise the TR however psychological models have been imported to community mental health settings and do not account for the complex contextual influence on interactions.
2	Determine the current level of evidence for an association between TRs and other variables including outcomes	Two systematic reviews of quantitative literature. Narrative summary of findings	<ul style="list-style-type: none"> - A number of methodological issues hindered meta-analysis and firm conclusions. - Equivocal evidence for association between TRs and outcome, clinical and demographic variables.
3	Analyse current understanding and assumptions in literature regarding the barriers and facilitators to TRs	Critical Interpretive Synthesis of (mostly) qualitative literature on TRs	<ul style="list-style-type: none"> - Current practice and the TR is effected by an ambiguity of purpose in community mental health. - TRs are characterised by three main factors: (dis)trust, (dis)respect and (dis)empowerment. - SUs and clinicians have different and possible conflicting needs for TRs.

13.1.2. Part II: Current practices and the impact of Joint Crisis Plans

In Part II, the aim was to investigate current views regarding the TR and investigate the impact of the JCP intervention. The specific objectives were to determine:

- 2.1. How key stakeholders view and understand TRs in community mental health settings, and the barriers and facilitators to the development of strong TRs.
- 2.2. If the JCP intervention affects TRs and if so, how?
- 2.3. If the TR at baseline was linked with outcome at follow-up.

13.1.2.1. Stakeholder views on Therapeutic Relationships

The first specific objective was to explore how SUs, CCs and psychiatrists viewed and understood the TR in routine practice. The results of the qualitative analyses presented in Chapters 8-11 suggested some commonalities between the groups regarding the types of interactions indicative of a strong TR. In particular, aspects described as 'person-centred' were important. For both clinicians and SUs, person-centred practices were analogous with a demonstration of respect. Feeling known as an individual with a life outside of mental illness was also fundamental to most SUs' experiences of the TR. Additionally, for SUs '*Being heard*' and '*Having control*' were important. For clinicians, a key facet of the TR was the achievement of common ground which clinicians believed led to improved SU engagement in treatment.

A number of barriers to such person-centred practices were presented by clinicians, including lacking time and bureaucracy such as paperwork. However, the key barrier was feeling '*Responsible and accountable*' (see 9.1.2) and acting to ensure the SUs and the community's wellbeing. The analysis suggested that clinicians prioritised acts that facilitated this role performance over acts that may be perceived as more person-centred. Such role conflict was coherent with the perception of many SUs that clinicians behaved in an inconsistent manner, which undermined SUs' trust that they would be helped and supported by the clinician. These findings were summarised in the model of TRs presented in Chapter 11 (see Figure

11-1) that defined the TR as an appraisal of *Consistent Respect* (discussed further in Section 13.2).

Some aspects of the qualitative data were investigated quantitatively in Section 12.1. In particular, lacking control (operationalised as perceived coercion) had a deleterious effect on SU ratings of the TR. Demographic, service use and experience, and clinical variables were also investigated. The statistical model of SU ratings suggested that, in addition to lower levels of perceived coercion, being younger, feeling similar to the CC (matched ethnicity), having lower levels of education, an affective psychoses diagnosis and no experience of self-harm, led to improved TRs. The statistical model generated for CC ratings suggested that stronger TRs were related to younger clinicians, non-White SUs, higher levels of functioning, fewer contacts and better engagement.

13.1.2.2. The impact of the Joint Crisis Plan intervention

The second objective of Part II was to determine whether the JCP intervention affected the TR and to provide information on the mechanism of action. Qualitative analyses provided some evidence for an effect on SUs' views of the TR, and no effect for clinicians. The quantitative analyses presented in Section 12.2 supported these findings. The initial model (adjusting for baseline values, missing data and trial site) indicated that the JCP positively affected SUs' ratings of the TR. Analyses also confirmed that the JCP did not significantly affect CCs' ratings. Following threads from the qualitative analysis, the effect on SUs' ratings disappeared when adjusting the model for whether the SU's full clinical team was in attendance and the length of relationship with the CC. These findings provided further support for the model of TR (Figure 11-1). The JCP provided an opportunity to demonstrate *Consistent Respect*. When the full normal team was not present, or clinicians left their post after the JCP, the SU interpreted such actions as demonstrating both a lack of respect and that the clinicians could not be trusted to implement the SU's wishes.

13.1.2.3. The predictive utility of Therapeutic Relationships for outcomes

The final objective of Part II was to determine whether SU and CC ratings of the TR were predictive of outcome at 18 months. Section 12.3 reported the results of multiple regression analyses testing the link between ratings on TRs and several outcomes including psychiatric admissions, harm to self and others and engagement in treatment. The results indicated that both SU and CC ratings *were* predictive of adverse outcomes. In particular, weaker SU ratings of the TR were associated with a small but statistically significant increased risk of: being sectioned (treated on a compulsory basis under the Mental Health Act); being hospitalised; self-harming; or making suicide attempts. Weaker CC ratings were associated with a small but significant risk of SUs: being sectioned; being hospitalised; harming others; or having lower levels of functioning. These are important outcomes and illustrate the potential clinical utility of measures of TRs.

See Table 13-2: Summary of findings for Part II, for a high level summary of these results.

13.1.3. Summary

The TR is important to individuals' experience of treatment in community mental health settings. Historically, and particularly in the context of community mental health, the TR has been poorly defined resulting in ambiguity of purpose and roles for clinicians and inconsistent and confusing experiences for SUs. These analyses suggest that a well-defined and operationalised measure of the TR may in fact provide some predictive utility for outcomes including hospitalisations and harm to self and others. In this context, a clear definition of the TR and understanding of the structural barriers to facilitating strong TRs is warranted.

Table 13-2: Summary of findings for Part II

Question	Priority Method	Secondary Method	Convergence/ Complementarity	Summary of key findings
1	QUALITATIVE	Quantitative	n/a	Qualitative analyses generated a new model of TRs, <i>Consistent Respect</i> , which is affected by context and interactional factors and produces <i>Agency</i> and <i>Trust</i> . Qualitative: <i>Agency</i> convergence established with quantitative measure of perceived coercion. Other aspects including: length of relationship, voice and trust not able to establish convergence. Stronger TRs for SUs were associated with lower levels of perceived coercion, being younger, feeling similar to the CC (matched ethnicity), having lower levels of education, a diagnosis of affective psychoses and no experience of self-harm lead to improved TRs. Stronger TRs for CCs were associated with younger clinicians, non-White SUs, higher levels of functioning, fewer contacts and better engagement. Qualitative analysis provided some evidence that TRs were affected for SUs but not for clinicians. This converges with the quantitative finding of positive effect of JCP for SU ratings, but not clinician ratings.
2	QUANTITATIVE	Qualitative	1. Convergence: reports of effect of JCPs 2. Complementarity: mechanism of effect in qualitative	Qualitative analysis suggests that the display of <i>Consistent Respect</i> in the JCP meeting and subsequent implementation of JCP contents was the mechanism of change in TRs. Quantitative secondary analyses controlled for 'consistency' by adjusting for length of relationship and for clinicians' presence at the JCP meeting. The effect of JCPs on the TR was not sustained, providing further evidence for the importance of 'consistency' in the model of TRs.
3	QUANTITATIVE	n/a	n/a	SU ratings at baseline predict their hospitalisations, including sectioning, experience of self-harm and suicide attempts over 18 month period. CC ratings at baseline predict SU functioning, hospitalisations and engagement over 18 month period.

A new model of TRs was produced, illustrating the TR as an ongoing, bi-directional appraisal and demonstration of *Consistent Respect*. Several barriers to the demonstration of *Consistent Respect* were indicated including: the lack of current evidence base for the TR; some SU and CC characteristics; and most importantly, repetitive interactions that are determined by the wider context (i.e., structurally defined role enactments). The JCP intervention provided a structured protocol to demonstrate *Consistent Respect* and by producing a 'new line of action' and reducing routine role enactments (see Section 11.3), the JCP improved SUs' views of the TR. However, in this analysis, improvements in SUs' views of the TR were undermined by a lack of clinician engagement and implementation of the contents of the JCP.

In the next three sections of this chapter present a discussion of the three major contributions of this thesis:

- Firstly, the new model of TRs suggested by this research and the implications of the 'consistency' component for practice;
- Secondly, role conflict and routine role enactments as the major impediment to the development of TRs in community mental health settings and its impact on decision making;
- Finally, the impact of the JCP intervention on the TR and how this was affected by implementation issues.

13.2. A new model of TRs: 'Consistent Respect'

The major contribution of this thesis is the development of a new model of TRs in community mental health. The new model proposes that interactions appraised as demonstrating *Consistent Respect* are indicative of strong and beneficial TRs. The appraisal of *Consistent Respect* has two main components: respect and consistency. The 'respect' component contained sub-categories of '*Being known*' and '*Being heard*' and is similar to aspects described in several qualitative studies^{151;152;236;237} and by Rogerian 'person-centeredness'^{79;80} i.e., clinicians demonstrating unconditional positive regard for SUs (see Chapter 2). Aspects associated with respect are the focus of much of the literature regarding TRs. For example, in a Rethink survey of almost 1000 SU in the UK, SUs stated that the three elements of care which are most important are 'having concerns taken seriously', 'choice of medication', and 'being treated with respect'.¹⁷⁷ A mixed methods study of SU and clinician views in Australia indicated that such aspects may be consistent across countries.²³⁸ Additionally, professional guidelines increasingly emphasise person-centeredness as the fundamental component to TRs.²³⁹ Such literature and guidance is also consistent with the CIS findings (see Chapter 4). However, the analysis in this thesis indicated that person-centred practice has not been implemented routinely (see Chapters 4 and 8). In this context, a model of TRs based on person-centeredness alone is inadequate. Therefore, the second and unique component of the model is 'consistency'. The consistency component covers both the regularity or constancy of respectful interactions, and the direct correspondence between talk and action (for example, honouring verbal commitments). The expectation of consistency extends the scope of appraisals of the other from one-on-one interactions (typical of most psychological models of TRs) to future actions, and firmly establishes the TR as an ongoing process rather than a state that is achieved.

This new model also extends the understanding of TRs in community mental health in two other ways. Firstly, this model includes a clear implication for SUs to demonstrate *Consistent Respect* for and to clinicians. In doing so, it positions the TR as a bi-directional process that is influenced not only by

characteristics of the clinician (e.g., capacity to demonstrate unconditional positive regard), but also those of the SU. Secondly, by considering the barriers to this demonstration, such as contextual pressures, this model captures aspects of power differentials that impact on the interactions between clinicians and SUs. This is consistent with the synthesising argument suggested by the CIS (Chapter 4) in highlighting the importance of context and in particular, uncertainty about goals and roles (see Sections 4.3.1 and 13.3).

The model of TRs presented in Figure 11-1 has some commonalities with a recent model of medical consultations published by the Health Foundation.²⁴⁰ In this model, general medical doctor's priorities and goals are presented as often competing against patients' priorities and goals, which is analogous to the *Context-defined 'me'* (Section 11.2.3), and illustrates how interactions and relationships are co-created by actors with differing needs and priorities. In this context, the new model of TRs proposed in this thesis may have some wider applicability outside of mental health care, however, the issues associated with mental health care such as power differentials and requirements for clinician action are probably unique.

As a new concept, however, consistency has not been a focus of past research. In this context, an important question is raised by this model: is consistency achievable in community mental health, particularly for individuals with psychotic disorders? As the model requires that both SUs and clinicians are appraised as consistent, each group will be discussed below.

13.2.1. Can service users be consistent?

The analysis suggested three main barriers to SU consistency: a lack of investment and respect for the process and clinician; a lack of self-efficacy and empowerment; and the impact of the illness such as losing insight too quickly. Each of these barriers will be discussed briefly below.

The first potential barrier to SU consistency is a lack of investment or respect for the process and/or clinician. The model of *Consistent Respect* suggests that this could be a result of past experiences within MHS (i.e., through 'Context-defined 'me'', see Section 11.2.3). A response to past experiences of disrespect and inconsistency from clinicians from some SUs was to 'play the game' (see Section 8.4.1.1) by only appearing to engage as the clinicians would like. This is similar to an analysis of SUs treated by Assertive Outreach teams in London¹⁵⁷ where SUs reported that not being listened to and being treated disrespectfully were reasons for disengagement. SU inconsistency may therefore be viewed as a response to past interactions with MHS.

A second barrier to SU consistency is a lack of empowerment. SUs may lack the experience of being held to commitments and/or the confidence to enact care plans themselves. Some authors have suggested that SUs with long-term conditions develop 'learned helplessness' and that clinicians should focus on assisting SUs to help themselves.¹⁵⁵ This is confirmed by research into barriers to SDM, which suggests that some SUs may lack the confidence, skills or experience to engage in the process, but are capable of learning this skill if given assistance.²⁴¹ Viewed in this context, the JCP intervention may both provide instruction and support for SUs on how to engage with clinicians, and through clinician demonstration of *Consistent Respect*, build confidence and self-respect, thus facilitating engagement and consistency. Rather than being a one-off however, the model proposes that this is an ongoing process where gains or deficits in agency are fed back into the TR and further improvements in agency (or deficits) are produced following interactions with clinicians.

These first two barriers provide further examples for how the JCP affected change. Where there are long-standing interactional problems, pre-existing negative expectations from both groups will prevent change in appraisals and expectations. Similarly, the learned helplessness suggested above will prevent SUs engaging in the process as their expectation is for a lack of involvement. However, if the interaction, through a new line of action such as the JCP, disconfirms such expectations, the *Context-defined 'me'* will be gradually altered, and if maintained, the TR would be improved.

The final possible reason for a lack of SU consistency is the loss of insight or capacity due to a relapse of psychotic condition. Clinicians in this study expressed some frustration at the speed with which SUs relapsed and, in the clinicians view, forgot about commitments they had made. Additionally, many clinicians described how some SUs relapsed too quickly to intervene. Relapse and loss of capacity may be consequences of psychotic illnesses and in cases where clinicians have needed to intervene and detain the SU, it may be difficult to revert to interactions that promote autonomy and demonstrate respect for the SU. The framework of *Consistent Respect* suggests in cases where SUs lack consistency, even through relapse, clinicians may view this as confirmatory evidence that the SU is not capable of honouring commitments. However, the concern that SUs relapse too quickly is contrary to evidence for the benefits of early intervention and relapse prevention,²⁴²⁻²⁴⁵ and perhaps is indicative of low morale in clinicians working with individuals with long-term psychotic conditions.²³³ (see also, Section 13.6.2)

In summary, issues related to SU inconsistency could be addressed through the TR and a process like the JCP. Through building trust in the process and clinician, by empowering the SU to engage in SDM and through maintaining hope and encouraging agency, many SUs could achieve consistency. However, what is clear from this model is that for SUs to achieve consistency, both clinicians and SUs need to approach interactions positively and with hope. In relationships that are stuck in negative role enactments, an external process such as the JCP may be the catalyst for change.

13.2.2. Can clinicians be consistent?

One of the implications of the model of *Consistent Respect* for clinicians is transparency and honesty. SUs in this study expressed dissatisfaction regarding clinicians not honouring or acting in a manner consistent with verbal commitments. The clear preference of the SUs in this thesis was for clinicians to always honour commitments. Considering the different roles clinicians are required to perform, being consistent would require having

difficult discussions regarding prognosis, unwanted treatments, or the potential for detaining someone in hospital without their consent.

An important question raised by this research is whether the SUs' right to truth i.e., clinician honesty, is always in the best interests of the SU. This has been described as a conflict between the 'principle of autonomy' (i.e., clinician honesty allows SU to make informed decisions) versus the 'principle of beneficence' (i.e., to reduce suffering).²⁴⁶ For example, what are the effects of telling a young person that they have a psychotic disorder and may need to take medication for the rest of their life? Or a clinician telling a SU in the initial stages of a relationship that should they be concerned about the SU's mental health they could involuntarily detain them?

Studies investigating disclosure of diagnosis suggest that many SUs are not informed of their diagnosis.^{167;247} Rather than being a factor of poor insight, often the reason for non-disclosure of diagnosis is clinical uncertainty.²⁴⁷ Individuals in contact with MHS for many years, such as the SUs interviewed for this thesis, may receive several diagnoses as their experiences are observed and diagnoses refined, which may be confusing and destabilising for the SU.²⁴⁸ Honest communication of such uncertainty, may undermine other aspects of SUs' views of the TR such as a perception of clinician expertise. It may also damage the clinician's assessment of 'common ground' (i.e., agreement on 'the problem' and the SU believing the clinician is able to help). Complete honesty, therefore, may actually undermine the development of a strong TR.

In this context, clinicians face a real dilemma. Full and transparent communication regarding negative prognoses, stigmatising diagnoses or clinical uncertainty may undermine the TR and distress or upset SUs (perhaps unnecessarily).^{159;167;247;249} Yet, the analysis in this thesis suggests that non-disclosure of such information, and subsequent discovery of non-disclosure, may undermine SUs' appraisals of the clinicians' trustworthiness and consistency, thus negatively affecting the TR. What is clear from this analysis, is that a nuanced approach is required and may be based on the clinicians' appraisal of the SUs' ability to understand and respond

appropriately to the information. Richard and colleagues²⁴⁶ present the use of 'therapeutic privilege' or the deliberate withholding of information with a SU's best interests in mind. They suggest a six step decision aid for using therapeutic privilege including consideration of the SU's ultimate and overall wellbeing, the detrimental consequences of denying the SU the right to know, and the SU's own preferences for information sharing.

In summary clinicians are required to make judgements about the effects of 'negative' information and whether full disclosure may generate negative effects for the SU and undermine the TR. Non-disclosure may result in a perception of inconsistency and SU distrust. In this context, the manner in which the information is delivered may be central to its effect,¹⁶⁷ however, further research is required to determine optimal communication strategies for delivering 'bad news' in community mental health and long-term conditions, and to assist clinicians in how and when to decide to use 'therapeutic privilege', and the effects on the TR.

13.3. Roles as a barrier to the development of Therapeutic Relationships

The second important contribution of this thesis is the recognition and description of the barriers to the development of a TR, in particular, the complex and competing demands and role requirements experienced by clinicians. The narrative review in Chapter 2 described how the CPA was introduced as a mechanism to ensure efficiency in delivery of MHS and in the late 1990s, risk management was emphasised as a key competency. As a consequence, the CPA process has been described as a 'defensive administrative process' with limited scope to promote and develop a TR.⁵¹ The CIS in Chapter 4 illustrated how the lack of clearly defined model of case management and goal of interactions led to role conflict in clinicians. This 'role conflict' is supported by data presented in Chapters 9 and 10 indicating the multi-faceted descriptions of clinician roles, and the difficulty described by some in maintaining a SU focus. Clinicians described how role enactments that fulfilled their professional accountabilities including bureaucratic concerns and managing risk, were often prioritised over

interacting with SUs in a 'person-centred' manner and how enacting the 'agent of social control' identity protected them from disciplinary action.

The finding regarding the multiple roles of clinicians is consistent with previous literature^{250;251} some of which presents this as a result of context.²⁵¹ Role conflict as a barrier to TRs is also consistent with previous research which has reported how clinicians are prevented from employing therapeutic skills or interventions due to context such as organisational culture,^{232;252} the medical consultation model,²⁴⁰ risk assessments/mitigation²³² and resource constraints.²⁵¹ Research also indicates that psychiatrists are more likely to be in favour of promoting SU choice and autonomy if they had fewer concerns about malpractice suits and placed high importance on a personal code of ethical practice.¹⁸² Furthermore, research investigating the prioritisation of risk management, such as limit setting, overt coercion and limiting SU autonomy, indicates adverse effects for the TR.^{123;156;253} In this context, there is fairly robust evidence to support the notion of role conflict as a barrier to TRs.

Stryker's Structural SI¹⁵ provided a theoretical underpinning to these results. Stryker proposed that individuals choose to enact certain identities (internalisations of positions and role expectations) depending on their salience and impact in wider social settings. In this context, the meaning attributed by clinicians to roles and tasks is important. While, the mechanisms used by professional groups in asserting their authority have long been a point of enquiry in sociology,^{26;254} there has been a limited focus on the meanings individual clinicians ascribe to their own work and how these impact on practice. A recent qualitative investigation of mental health clinicians' experiences²⁵⁵ indicated that 'professional identity' may be protective in the face of clinical uncertainty. That is, by adopting an identity of a 'clinical psychologist' for example, one has a model through which to interpret and act in clinical situations, however there was also a suggestion in that study that this may lead to the types of repetitive and rigid behaviours suggested by participants in this thesis (see Section 9.3.2: Ritualised interactions). Furthermore, a qualitative study of community psychiatric nurses suggests that they act to ensure the legitimacy and recognition of their profession.²⁵⁶ There is also some suggestion that role

enactments are resistant to alteration, even when directly requested or addressed. For example, in a randomised trial investigating treatment recommendations,²⁵⁷ psychiatrists were given two vignettes of 'major mental illnesses' and asked to recommend treatments as they would normally, to say what they would recommend if asked by a SU 'what would you do if you were me?' (i.e., an attempt to elicit the psychiatrist's personal view), and what treatment they would want for themselves. The results indicate that even when directly asked for a personal perspective, psychiatrists responded according to routine recommendations (which differed from what they would want for themselves). In this context, performance of professional roles has greater salience and impact (i.e., avoiding detrimental effects for the profession and professional self) and may be partly informed by ambiguity and uncertainty in community mental health care.

In summary, the model of *Consistent Respect* suggests that role enactments which comply with policy/managerial directives and fulfil clinicians' needs to protect themselves, but are at odds with SUs' autonomy and need to be heard, undermine the TR.

13.3.1. Making decisions and influencing change

Analyses in this thesis suggest that having control is fundamental to SU's assessment of the TR. Like previous research,²⁵⁸ the vast majority of SUs wanted to be involved in and influential in decisions made about their care. SUs appraised clinician inflexibility in treatment decisions as a lack of respect for their lived experience (see Section 8.4.1) which prompted some SUs to give up efforts to engage in efforts to influence change. This is consistent with the Rethink survey described above,¹⁷⁷ in which 9% of SUs surveyed reported attempts to change their medication and having this refused by clinicians; 16% of these SUs then stopped the medication without advice/supervision. It is clear that some behavioural acknowledgement (e.g., negotiation of a trial period or reducing dose) of the SU's perspective is central to ensuring a strong TR. This represents true 'SDM' as defined by Charles and colleagues¹⁶⁵ as including bi-directional

information sharing, expressing preferences and jointly deciding to enact the change (see Section 5.1.3).

The data presented in this thesis suggest that the principle of SDM is widely accepted, but is difficult to achieve in routine clinical care. This tallies with previous research which has suggested a number of barriers, including not providing complete and accurate information to SUs,¹⁶⁴ nurses lacking sufficient time²⁵⁹ and deficiencies in psychiatrists' communication skills.^{171;176} The psychiatrists in this thesis showed a commitment to SDM, but there was some evidence that their behaviours and skills did not support this desire. Further, many clinicians described concerns about the potential for conflict between encouraging SU choice and involvement in decisions, and the clinicians' view of what is in the SU's best interest. For many the response to this conflict was to exert control. Ong and colleagues¹⁷¹ reviewed many aspects of doctor-patient communication and suggest that one of the key elements is the clinician's need to maintain control. Psychiatrists may overtly exert control through the MHA, but also in more subtle ways such as interruptions and questioning. Quirk and colleagues²⁶⁰ conversation analysis of psychiatric consultations also illustrates how psychiatrists may influence choices in a way that appears to fulfil the SDM ethos but is actually an exertion of control. The analysis in this thesis supports this proposition. As discussed, clinicians reported many roles which were often in conflict, in particular the demands of 'person-centeredness' versus being a '*Responsible and accountable*' clinician (see Sections 9.1.2 and 10.1.1). The model of TRs presented in Figure 11-1 suggested that the accountability role is more salient for clinicians and thus is more regularly enacted. To facilitate the accountability role, clinicians in this study, mostly but not exclusively psychiatrists, used interpersonal pressures and similar strategies to ensure they were in control of decision making.

In addition to clinician barriers to SDM, there is some research illustrating how deficiencies in SUs' may also impede true collaboration. Hamann and colleagues' RCT of training SUs in SDM²⁴¹ illustrated that training in collaboration can improve SUs attitudes to and confidence in sharing decisions with clinicians. Similarly, in a qualitative study of clinician and SU

perspectives on SDM, Tee and colleagues²⁶¹ suggest SUs need support and education to enhance confidence and participation in decision making. In this context, SUs may lack the required skills, experience or status to effectively engage in collaboration with clinicians.

The JCP Facilitator is therefore fundamental to the JCP intervention by decreasing routine role enactments, empowering SUs and monitoring clinicians to ensure true collaboration (see Section 11.3). Such advocacy has been presented as a critical component of the mental health care system²⁶² particularly, and as indicated by the data in this thesis, in situations where SUs lack the status or ability to influence change. However, the impact for some clinicians of such advocacy was that the control was reversed. That is, rather than decisions being clinician led, decisions were SU led and some clinicians reported feeling uninvolved in the process as a consequence. There were benefits for the SU in achieving more control, but the lack of engagement of clinicians in the process meant that the SUs did not always achieve what they wanted. In this context the delivery of the intervention fell short of its intention to facilitate a form of SDM (discussed further in Section 13.4) and raises a question about the feasibility of achieving SDM in contexts with power imbalances and complex role requirements.

13.4. The Joint Crisis Plan improves Therapeutic Relationships

The third key contribution of this thesis is the finding that the JCP positively affected SUs' views of the TR. Previous research using qualitative methods or unvalidated measures of TRs¹⁸⁰ had provided some preliminary evidence for a positive effect of the JCP and similar interventions. Additionally, one trial had investigated the impact of the F-PAD (see Chapter 5), on ratings on the WAI and found a positive effect at one month. The results of this thesis extend such findings in two important ways: firstly, by establishing that the positive effects of the JCP on TRs are sustained at the 18 month mark; and secondly, by using mixed methods to establish the mechanism through which interventions such as the JCP may create such an effect.

The model of TR presented (see Figure 11-1) provided the mechanism through which the JCP produced change for SUs. The JCP Facilitator ensured that routine role enactments of clinicians were reduced in many cases, thereby producing a context in which SUs and clinicians jointly decided future actions in the event of a crisis. That is, the JCP meetings provided an opportunity for clinicians to demonstrate *Consistent Respect* for SUs, which built SU *Agency* and *Trust*. However, deficits in clinicians' engagement in the JCP intervention undermined any improvements in the TR. Conversely, the JCP did not create a 'new line of action' or sufficiently change SUs' routine role enactments, and therefore clinicians' views of the TR were not affected.

The deficit in clinician engagement was unexpected as the previous trial of the JCP had found that clinicians were quite positive towards the JCP intervention.¹⁸⁰ However, it is consistent with qualitative investigations of AS which have indicated that clinicians did not know enough about the intervention and did not find it useful.^{185;190}

The intervention was delivered to a high level of fidelity (see 7.2.3), however, what is clear from the analysis in this thesis is that the fidelity measure was flawed. The key mechanism of effect of the JCP was found to be the demonstration of *Consistent Respect* for the SU – something that was not consistently achieved in the trial and not covered by the fidelity measure. In this context, the implementation was reported as meeting fidelity, but the *intention* of the intervention was not achieved in all cases. For example, it was not sufficient for clinicians to be present in the meeting; clinicians needed to actively participate in the discussion. It was also not sufficient for the clinicians to agree to the JCP content in the meeting but not enact the plan in the event of a crisis. Neither of these scenarios would have been recorded on the fidelity measure, but both were fundamental to the SU's appraisal of *Consistent Respect*. The fidelity measure was primarily focused on the delivery of the intervention by the Facilitator, not the Facilitator's success in creating a 'new line of action' that successfully demonstrated *Consistent Respect*.

In this context, the implementation of experimental interventions, like policy, requires careful consideration of the *intention* of the process and its measurement.

13.4.1. Barriers to implementation

Investigations of adherence to clinical guidelines in mental health suggest that while patient outcomes may be improved by adherence, actual compliance is limited.²⁶³ Research suggests that barriers to implementation include perceptions of a negative impact on interactions between professionals and patient groups; poor 'fit' with (local) organisational goals; poor 'fit' with existing skill sets of clinicians; poor evidence base for the intervention ; questionable patient benefit; low levels of resources either to implement change or routine practice.²⁶³⁻²⁶⁵ Some of these barriers were raised by clinicians interviewed for this thesis. In particular, clinicians raised concerns regarding the potential 'interference' of the JCP and the Facilitator in their ongoing, routine interactions.

A recent investigation of MHS in the US²⁶⁶ provides further insights into contextual factors that may influence compliance with guidelines or evidence based practice (EBP). In this study, the authors investigated the association between clinician attitudes towards EBP and organisational climate and culture in 1112 mental health service providers. Using the Organisational Social Context (OSC) scale, 'culture' was defined as the 'expectations that govern how work is done' and included dimensions of rigidity (individuals have little discretion or flexibility), proficiency (SU focus and appropriate skills) and resistance (no interest in change or new ways of working). 'Climate' was defined as the 'psychological impact of the work environment' and included dimensions of engagement (workers are engaged and concerned), functionality (workers feel supported to do a good job and have role clarity) and stress (workers feel emotionally exhausted). The authors found that clinicians' attitudes to EBP were most strongly predicted by a 'proficient' culture, that is, an organisational expectation to prioritise SU well-being, to be competent, and to have up-to-date knowledge. Importantly, they also found that clinicians working in a stressful climate were less likely to adopt EBP if dictated by policy or

regulatory mandates. The authors suggest that successful implementation of EBP would be facilitated by secondary strategies that supported the development of 'proficient' and positive cultures.

While the JCP intervention was still an experimental intervention in the CRIMSON trial, many of the above findings would seem to apply. It is clear from this analysis that the delivery of the JCP intervention 'as intended' was partially prevented by structural and context barriers such as existing attitudes to the CPA and care planning, ambiguous treatment goals and conflicting role requirements. Using the definitions of culture and climate from the study above,²⁶⁶ the qualitative analyses suggest that the 'culture' of the Trusts in the CRIMSON Trial may have been characterised as 'rigid' and 'resistant', rather than 'proficient' and the climate as stressed and thus resistant to directives for new ways of working. In this context, the JCP altered routine role enactments in some instances, but the organisational culture and climate ultimately determined its effect. Organisational change programs, in addition to the implementation of the intervention may therefore be indicated and there is some research evidence for the effect of such a strategy.²⁶⁷

For the JCP to be successfully implemented, some changes are required. Firstly, clinicians need a reason to prioritise interactions that demonstrate *Consistent Respect*. As such there is a need for a clear evidence base (see Section 3.4) for the TR and SU involvement in decision making that incentivises clinicians who are motivated by the best interests of the SU. Furthermore, the alteration of practice audits to include aspects associated with patient satisfaction will provide further incentives to prioritise interactions that demonstrate *Consistent Respect*. Secondly, the impact of team culture and climate needs to be assessed. This research suggests that an adoption of an 'opt-in' approach for teams rather than requiring participation may be beneficial. Finally, intervention at the organisational culture and climate level, such as promoting flexibility and discretion in practice, continual professional development and the use of EBP, may be beneficial. In summary, the JCP needed more developmental work in teams to improve engagement in its implementation.

13.5. Limitations and strengths of this thesis

The reality of conducting mixed methods research within a trial with tight timeframes meant that it was not possible to investigate several 'threads' that may be of interest in the model of TRs and in explaining the mechanism of effect of the JCP. Such threads include some convergent quantitative measures of 'trust' and 'respect' and qualitative enquiries regarding the importance of 'hope' in interactions. These may provide interesting avenues for further research. In hindsight, and particularly in the context of CC data about the importance of involving others and deficiencies in the implementation of the JCP, it would have been helpful to interview the JCP Facilitators about their experiences of building relationships with teams and SUs.

Furthermore, while the JCP protocol did not prevent the use of existing clinical meetings or require all members of the clinical team to be present during the JCP meeting, this analysis suggests that these factors may have improved the effect of the intervention. In hindsight, more attention needed to be paid to building a case for the intervention when initially approaching clinical teams.

It should be noted that clinicians who were less positive about the intervention were also less likely to agree to attend interviews/focus groups. Two strategies were used to account for this. Firstly, process data provided some proxy measure of clinician views e.g., the attendance at the JCP meeting which was controlled for in quantitative analyses. Secondly, negative views of those attending focus groups/interviews were actively sought and considered during the analysis. Nevertheless, it should be acknowledged that overall impression of clinicians in routine care may have been less enthusiastic than the results of this analysis suggest and further barriers to the TR and the JCP may have been missed.

The views of SUs and clinicians were collected retrospectively and in all cases, many months after the JCP meeting. This was a deliberate strategy to minimise the chances of attendance at an interview/focus group affecting responses to the intervention. This analysis also relied on reports rather than direct observation of both routine interactions and those during the

JCP intervention. In this context, it is possible that key facets of routine interactions and the JCP intervention were missed due to poor recall and reporting bias. Future work will analyse audio recordings of the JCP planning meetings to examine convergence with the key categories from the qualitative analyses and the final model proposed.

This thesis focussed on the policy context in England. It is possible that the generalisability of the model, and in particular results regarding goal and role ambiguity, may be limited. However, many other countries use a similar model of community intervention and have a similar legal framework allowing for compulsory treatment. Additionally, in countries where types of Advance Statements have been introduced, many clinicians have expressed reservations similar to those of the clinicians interviewed for this thesis, regarding difficulties implementing SU choice.^{185;187;188;268} Also, the recent analysis of barriers to implementing EBP discussed above²⁶⁶ suggests that uptake of EBP is adversely affected by structure, organisational culture and climate. In this context, it is feasible that the results of this thesis have some applicability to similar contexts, however, this remains to be established.

Limitations specific to the CIS and quantitative analyses are presented in Sections 4.4.1, 12.1.5.3 and 12.2.4.2.

Despite these limitations, several strengths of this thesis should be acknowledged. One of the key strengths of this thesis is the amount and quality of the data collected through the CRIMSON trial. The successful conduct and management of clinical trials is essential in determining whether an intervention has the postulated effect. Errors in design and management of trials risk introducing bias, which may make results misleading. The CRIMSON trial was adequately powered, with high levels of outcome data obtained. Randomisation was conducted by an online system and masking was maintained in a high proportion of cases. In this context, the CRIMSON trial and the data collected in this thesis are unlikely to have been affected by bias.

A particular strength of this thesis is how the review of policy in Part I and the inclusion of multiple stakeholder perspectives provided a view of interactions from both a micro level and at a macro level. In this way, the results presented provide an understanding of a social phenomenon in context. Most previous models or explorations of the TR do not account for contextual influences and, according to this analysis, therefore miss a vital component of the process. Furthermore, the mixed methods approach used in this thesis provided a depth and richness to the exploration of the TR and the impact of the JCP. Rigorous qualitative and quantitative methods were used and were well integrated.

13.6. Implications

13.6.1. Implications for research

As discussed, one of the limitations of this research is the reliance of participants' reports of the JCP intervention and routine interactions rather than direct observation. This is particularly pertinent given the findings regarding influencing change and use of interpersonal pressures in decision making. While participants' reports are not invalid, and in fact provide an important appraisal of the interactions, there are limits for recommending improvements in communication without direct observation of current practice. This will be partially addressed through a planned analysis of JCP planning meeting recordings, guided by research using conversation analysis.^{154;260}

Current government directives call for a form of SDM that involves SUs in all decisions about their care.⁷⁸ As discussed in Section 13.3.1, there are significant barriers to the delivery of SDM in routine community mental health care in particular power and routine role enactments. The JCP was at least partially successful in decreasing some routine role enactments, but may have inadvertently added to clinician concerns about patient and public safety, or not sufficiently included them in the process of decision making. Further research is therefore required in methods of communication that facilitate transparent and authentic communication between (in particular) psychiatrists and SUs, and methods which even out power imbalances

between clinical teams and SUs. Furthermore, and in the context of deficiencies in implementation of the intervention, research into methods facilitating the implementation of experimental interventions which require the engagement of clinicians is warranted.

As discussed in Section 13.2.2 a key implication of *Consistent Respect* is the need for honesty and transparency in interactions. However, there is little evidence in the literature regarding impacts of honesty in communication in MHS, particularly in the context of delivering bad news such as stigmatising diagnoses. Further research is required regarding the methods facilitating the delivery of 'bad news' with the least negative consequences for SUs, particularly in mental health care where communication may be hindered or coping mechanisms impaired by illness factors. Additionally, it would be interesting to investigate the outcomes of full transparency in routine care, particularly in terms of the TR and trust in clinicians.

Further, trust was a key theme underlying many of the findings in this thesis. As discussed there is very little research into barriers and facilitators to trust in MHS. This thesis indicates that research may usefully focus on the ways in which clinicians decide to trust SUs and the implications of such trust, for example, through 'positive risk taking'.

The final research implication relates to the measurement of TRs. The reviews in Chapter 3 and the analyses of Chapter 12 suggest that current measurement of the TR, specifically in community mental health settings, is inadequate. The model of *Consistent Respect* clearly indicates a need to capture the contextual influences on interactions. Furthermore, aspects of trust, perceived similarity and morale should be considered in measurement of the TR. The most common measure of the TR is the WAI which is based on Bordin's model of TR. There is some evidence to support the three components of Bordin's model in this thesis, but the lack of context, trust, similarity and morale undermine its efficacy for measuring TRs in community mental health. A measure has been developed to consider the 'dual roles' of clinicians in mandated treatment which has some promising psychometric properties.²⁶⁹ However, more research needs to be done to

assess its efficacy and that of other recent measures²⁷⁰ in capturing aspects of the TR suggested by this thesis.

13.6.2. Implications for practice

There are several implications for practice arising from this thesis. Firstly, the bi-directional nature of the TR and the impacts of clinicians' behaviour on the relationship suggest a need for reflective practice and consideration on how clinicians' own behaviour may be affecting the relationship. This is particularly pertinent in the context of promoting SDM where aspects of communication may unconsciously undermine clinicians' attempts to promote collaboration. The need for adequate clinical supervision to facilitate reflection and professional development is clear. Furthermore, programmes designed to continually assess clinician performance may be warranted. To ensure practice is person-centred, feedback should be from SUs themselves, perhaps in addition to clinical peers or managers. For example, a randomised trial of regular feedback to clinicians from SUs, indicated measurable benefits in terms of improved outcomes.²⁷¹ Clinical training should also focus on interactional components, particularly for psychiatrists, to ensure power differentials do not negatively influence communication and decision making.

Secondly, clinician consistency in talk and actions was particularly important for SUs in appraising the TR. Training clinicians in transparent communication, particularly in the context of unwanted treatments, and/or clearly communicating what MHS can or cannot deliver is indicated by these analyses. Furthermore, training clinicians in delivering 'bad' or 'negative' news appears vital in ensuring the development of helpful TRs.

The deficits in clinician engagement in the JCP intervention were unexpected and had significant impacts on the effectiveness of the intervention. This was particularly surprising considering that the JCP had the potential to decrease clinicians' workload by preventing future admissions or through producing a detailed crisis plan that could be used in routine care. The audit of CPA care plans¹⁷⁸ indicated that the JCP was not utilised by clinicians, despite some clinicians describing in focus

groups/interviews that the content was more detailed and useful than routine CPA care plans. This lack of use of the JCP and the difficulties in engaging clinicians in the delivering the intervention (see Table 7-6) suggests a level of antipathy towards the research process. In this context, programmes designed to engage clinicians in research, such as the 'scientist-practitioner model' used in clinical psychology²⁷² could be helpful. Engaging clinicians in thinking about research which assesses treatment delivery could lead to greater understanding of and adherence to evidence-based guidelines and participation in research itself. Further, it could engender the type of reflective processes outlined above.

The final implication for practice is the finding that older clinicians rated TRs as weaker than their younger colleagues (see Section 12.1.4.2), suggesting possible issues with decreased morale and hopefulness. This may be influenced by the demographics of the SUs involved in the CRIMSON trial as they all had long-term relapsing conditions. There is some research to suggest that clinicians hold more or similar stigmatising views to the general community and that this may particularly be the case in long-term conditions where positive stories of recovery are few.^{93;273} Additionally, the concerns expressed by clinicians regarding SUs relapsing too quickly to intervene (see Section 13.2.1), is also suggestive of a lack of hope amongst the clinicians interviewed for this study. In this context, programmes designed to encourage morale, hope and positivity in the face of long-term conditions is suggested by this analysis. Research on training in psychosocial interventions, for example, indicates that such training improves clinicians' attitudes towards SUs, which in turn enabled SU confidence and autonomy.²⁷⁴

13.6.3. Implications for policy

Recent policy and practice guidelines have emphasised the importance of the TR and in particular have focused on improving interactions through encouraging SU involvement in treatment and decision making. The results of this thesis suggest that this recent focus is warranted. However, further guidance is required regarding about how to achieve SDM in the context of competing and contradictory role requirements.

A second clear implication of this thesis is the need to address and define the 'treatment contract' in community mental health and in particular the goal of interactions. Are MHS a 'crisis only' service aiming to stabilise SUs and discharge them back to primary care? Or are MHS there to provide ongoing, long-term maintenance support? The lack of consensus regarding the goal of interactions among CCs interviewed for this thesis led to inconsistency in practice between clinicians and unnecessary stress within individuals. Clear definition of what the MHS are able to deliver and clear communication of this to SUs will promote 'consistency' and thereby have the potential to improve the TR.

The barriers described by clinicians to person-centred practice represent the third implication for policy arising from this thesis. The prioritisation of accountability and risk management roles over demonstrating *Consistent Respect* to SUs, suggests a need to incentivise clinicians to deliver the latter. This may be assisted by improving the evidence based for person-centred approaches described in 13.6.1. Additionally, quality assessments of MHS should be shifted to aspects indicative of 'person-centred' care. Patient satisfaction and 'quality' of delivery should be given higher priority than the process and administration. For example, Priebe, McCabe and colleagues' trial of a structured communication intervention²⁷⁵ addressing met needs and feeding back levels of SU satisfaction to clinicians, found improvements in unmet needs, satisfaction and quality of life. Routine clinical care should be assessed by similar measures.

The final policy implication is for the CPA. One of the recurrent themes throughout this thesis was the SU and clinician ambivalence towards the CPA care planning process. There is some consensus in the literature that the CPA has failed to achieve its original aims.⁵¹ This analysis also suggests that the CPA as currently assessed and delivered is not achieving one of its original intentions – that of involvement of SUs in care planning (see Chapter 2). From the analysis in this thesis, clinicians do not value the CPA as they perceived no clinical benefit in the process. Rather, the majority of clinicians perceived the CPA care plan as a task required and assessed by bureaucrats. One problem is the manner in which the CPA care plan is

assessed (i.e., the completion of the task, rather than the content of the plan) which promotes unreflective completion of the plan and the perception of a lack of clinical benefit. In this context, assessment of the *content* and in particular the personalisation of care plans, should be the focus of assessment rather than (or perhaps in addition to) their completion. Perhaps the fundamental issue with the CPA is the lack of clearly defined goal or purpose. The lack of focus on the CC role, the ambiguity regarding model of case management and the conflict between risk management and promotion of SU autonomy has resulted in marked variation in treatment delivery. The clear implication is for a revised statement of purpose of the CPA, clear delineation of case management model and purpose, and clinicians' roles within the system, in order to provide consistent, unambiguous guidance for clinicians. If done successfully, the analysis of this thesis suggests that there will be measurable benefits for TRs in community mental health.

13.7. Conclusion

The Therapeutic Relationship is defined as an appraisal of interactions and individuals within the delivery of mental health treatment. Both clinicians and mental health service users agree that strong Therapeutic Relationships are those that are appraised by stakeholders as demonstrating *Consistent Respect*. However, clinicians' demonstration of this may be hindered by a lack of evidence of the effect of such patient-centred practices, conflicting role requirements and ambiguity regarding the goal of interactions. Service users' demonstration of *Consistent Respect* may be hindered by past negative experiences of mental health services. The Joint Crisis Plan was successful in lessening the effect of such barriers, and improved the Therapeutic Relationship when clinicians engaged as intended. Future implementation of the Joint Crisis Plan and routine demonstration of *Consistent Respect* requires improving the evidence base for such practices, assessment of the organisational culture and structural barriers and a resultant tailoring of the implementation, policy and practice guidance. Additionally, altering the assessment of community mental health delivery to include measures of quality (particularly measured by an individual focus or personalisation) and satisfaction is indicated.

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Appendix A SR1: Predicting outcomes from TR ratings

	Study					Significant findings		Non- Significant findings	
Author	Rater of TR	TR Scale	TR Time (mths)	Outcome Time (mths)	Test	Result	Test	Result	
Fakhoury	CC	HAS	B	9	Y/N for new SU	beta = - 0.21, p=0.04	Y/N established SU	Beta = - 0.04, p=0.53	
Priebe	SU	HAS	B	20	Right Tx: HI	r= -0.27, p<0.05	Understanding HI	ns - not reported	
					Feeling post session: HI	r=-0.30, p<0.01	CM criticism -HI	ns - not reported	
							CM involvement- to HI	ns - not reported	
Clarke	CM	WAI	B	24			Time to hospitalisation	Beta-not reported NS	
Olfsen	CM	AES	B	3			Y/N H	t=.2, p=.88	
Calsyn	SU	WAI	3	18	days in stable housing	r=0.21, p<0.05			
	SU	WAI	15	18			days in stable housing	r=0.04, NS	
	CC	WAI	3	18			days in stable housing	r=0.03, NS	
	CC	WAI	15	18	days in stable housing	r=0.29, p<0.01			
Chinman	SU	WAI	B	12			days homeless	ns - not reported	
	SU	WAI	3	12	days homeless	F=8.54, p<0.001			
	SU	WAI	12	12	days homeless	F=16.38, p<0.002			
Clarke	CM	WAI	B	24	time to homelessness	beta = 0.03, p=0.002			
Priebe	SU	HAS items	B	20			Housing index	ns - not reported	

Abbreviations: AES: Active Engagement Scale; B: baseline; CC: care coordinator; CM: case manager; HAS: Helping Alliance Scale; HI: Hospital Index; NS: not significant;; SU: Service user; TR: therapeutic relationship; Tx: treatment; WAI: Working Alliance Inventory; Y/N: yes/no; Y/N H: dichotomous variable Hospitalised or not.

Appendix A (continued)...

	Study					Significant findings		Non- Significant findings	
	Author	Rater of TR	Measure of TR	TR Time (months)	Outcome Time (months)	Test	Result	Test	Result
Medication Adherence	Holzinger	SU	HAS	B	3	clozapine compliance	beta =.288, p=.049		
	Olfson	CC	AES	B	3	compliance Y/N	chi-squared =6.2, p=.04		
	Weiss	CC	WAI	B	7	time to non-adherence	Beta = -.0528, p<.001		
						time to adherence	Beta = 0.0353, p<0.05		
Global and social functioning	Catty 2010	SU	HAS	B, 6, 12	6, 12, 18			GAF	ns - not reported
		VW	HAS	B, 6, 12	6, 12, 18	GAF	Beta=0.20, p<0.001		
		SU	HAS	B, 6, 12	6, 12, 18			social disability	ns - not reported
		VW	HAS	B, 6, 12	6, 12, 18	social disability	beta = -0.08, p<0.001		
Vocational Functioning	Chinman	SU	WAI	B, 3, 12	12			social support	ns - not reported
	Goering	SU	WAI	9	18			SLOF	F=2.60, NS
	Priebe	SU	HAS items	B	20	CM Understanding to work axis	r=0.40, p<0.01	CM involvement to work axis	ns - not reported
						CM criticism to work axis	r=-0.35, p<0.05	Right Tx: work axis Feeling post session: work axis	ns - not reported ns - not reported

Abbreviations: B: baseline; CM: Case manager; GAF: Global Assessment of Functioning; HAS: Helping Alliance Scale; NS: not significant; SLOF: Social Functioning; SU: Service user; TR: therapeutic relationship; treatment; VW: vocational worker; WAI: Working Alliance Inventory; Y/N: Yes/No.

Appendix A (continued)...

	Study					Significant findings		Non- Significant findings	
	Author	Rater of TR	Measure of TR	TR Time (months)	Outcome Time (months)	Test	Result	Test	Result
Vocational Functioning (continued)	Catty 2008	SU	HAS	B, 6, 12	6, 12, 18	occupational obtainment Y/N	OR =-1.05, p<0.005		
						number of hours in paid job	beta=-0.05, p=0.009		
		VW	HAS	B, 6, 12	6, 12, 18	occupational obtainment Y/N	OR =-1.06, p<0.001		
QOL						number of hours in paid job	beta=-0.07, p=0.001		
	Catty 2010	SU	HAS	B, 6, 12	6, 12, 18	Key worker TR	r=0.01, p=0.013	VW relationship	ns - not reported
		VW	HAS	B, 6, 12	6, 12, 18				ns - not reported
Symptoms	Chinman	SU	WAI	3	12	3 levels of TR: life satisfaction	F=3.91, p<0.001		
	Calysn	SU	WAI	3	18	BPRS	r=-0.21, p<0.05		
		SU	WAI	15	18			BPRS	r=-0.06, NS
		CC	WAI	3	18			BPRS	r=-0.16, NS
		CC	WAI	15	18	BPRS	r=-0.21, p<0.05		
								Addiction severity	r=0.09, NS and
		SU	WAI	3 and 15	18			Days using substances	r=0.07, NS
		SU	WAI	3 and 15	18				r=-0.09, NS and
								r=-.14, NS	
								r=0.03, NS and	
		CC	WAI	3 and 15	18			Addiction severity	r=-0.02, NS
		CC	WAI	3 and 15	18			Days using substances	r=0.04, NS and
									r=-0.08, NS

Abbreviations: B: baseline; BPRS: Brief Psychiatric Rating Scale; Helping Alliance Scale; NS: not significant; QOL: Quality of Life; SU: Service user; TR: therapeutic relationship; treatment; VW: vocational worker; WAI: Working Alliance Inventory; Y/N: Yes/No.

Appendix A (continued)...

	Study					Significant findings		Non- Significant findings	
	Author	Rater of TR	Measure of TR	TR Time (mths)	Outcome Time (mths)	Test	Result	Test	Result
Symptoms (continued)	Cunningham	SU	WAI	3	9	BPRS	r=-0.27, p<0.01		
		SU	WAI	3	18	BPRS	r=-0.16, p<0.05		
		SU	WAI	15	9			BPRS	r=-0.12, NS
		SU	WAI	15	18			BPRS	r=-0.04, NS
	Goering	SU	WAI	9	18			BPRS	F=0.12, NS
	Catty 2010	SU	HAS	B, 6, 12	6, 12, 18			HAS re clinician: PANSS	ns - not reported
		SU	HAS	B, 6, 12	6, 12, 18			HAS re VW: PANSS	ns - not reported
		SU	HAS	B, 6, 12	6, 12, 18			HAS re clinician: Depression	ns - not reported
		SU	HAS	B, 6, 12	6, 12, 18			HAS re VW: Depression	ns - not reported
		VW	HAS	B, 6, 12	B, 6, 12	PANSS - negative	Beta = -0.09, p=0.001		
		VW	HAS	B, 6, 12	B, 6, 12	PANSS - positive	Beta = -0.11, p<0.001		
		VW	HAS	B, 6, 12	B, 6, 12	PANSS - general	Beta = -0.16, p<0.001		
		VW	HAS	B, 6, 12	B, 6, 12			Depression	Beta = -0.04, p=0.069
	Chinman	SU	WAI	B, 3, 12	12			Depression	ns - not reported
		SU	WAI	B, 3, 12	12			Psychotic symptoms	ns - not reported
		SU	WAI	B, 3, 12	12			Addiction	ns - not reported
		SU	WAI	B, 3, 12	12			Addiction	ns - not reported

Abbreviations: B: baseline; BPRS: Brief Psychiatric Rating Scale; HAS: Helping Alliance Scale; NS: not significant; PANSS: Positive and Negative Symptom Scale; SU: Service user; TR: therapeutic relationship; VW: vocational worker; WAI: Working Alliance Inventory.

Appendix B SR2: Demographic Associations of TR

Predictor	Author	Rating of TR	TR Scale	TR Time (mths)	Predictor Time (mths)	Test	Significant findings	Not significant findings
Age	McCabe	SU	HAS	first admission	same	U/MV	r=0.22, p<0.04/B= 0.21, p<0.001	not reported
		SU	HAS	Hospitalised 1.5 years	same	U/MV		not reported
	Hamann	SU	HAS	Discharged 1.5 years	same	U/MV		r=-0.041
		DR	QTA	Before discharge	Same	U		r=-0.040
	Calsyn	SU	QTA	Before discharge	Same	U		r=0.14
		CC	WAI	3 months	same	U		r=-0.05
	Catty	SU	WAI	3 months	same	U		not reported
		VW	HAS	6 months into trial	baseline	U/MV		not reported
Age at first MHS use	Catty	SU	HAS	6 months into trial	baseline	U/MV		not reported
Age at first MHS use		VW	HAS	6 months into trial	baseline	U/MV		not reported
Duration of illness	Hamann	SU	QTA	Before discharge	Same	U		r=-0.034
		DR	QTA	Before discharge	Same	U		r=0.034
Education	Hamann	SU	QTA	Before discharge	Same	U		r= -0.097
		DR	QTA	Before discharge	Same	U		r=0.024
	Catty	SU	HAS	6 months into trial	baseline	U/MV		not reported
		VW	HAS	6 months into trial	baseline	U/MV		not reported
Ethnicity	Calsyn	SU	WAI	3 months	same	U		r=-0.06, p>0.05
		CC	WAI	3 months	same	U		r=-0.01
Gender	Hamann	SU	QTA	Before discharge	Same	U		r=0.064
		DR	QTA	Before discharge	Same	U	r=0.138, p<0.05	not reported
	Calsyn	SU	WAI	3 months	same	U		r=-0.04
		CC	WAI	3 months	same	U		not reported
	Catty	SU	HAS	6 months into trial	baseline	U/MV		not reported
		VW	HAS	6 months into trial	baseline	U/MV		not reported
Gender match	Catty	SU	HAS	12 and 18 months	same	U/MV		not reported
Gender match		VW	HAS	12 and 18 months	same	U/MV	p<0.01/ 3.21, 0.67 to 5.76, p= 0.02	not reported
Immigrant status	Catty	SU	HAS	6 months into trial	baseline	U/MV	p<.01	not reported
		VW	HAS	6 months into trial	baseline	U/MV		not reported
Living status	Catty	SU	HAS	6 months into trial	baseline	U/MV		not reported
		VW	HAS	6 months into trial	baseline	U/MV		not reported

Abbreviations: HAS: Helping Alliance Scale; MV: multivariate; QTA: Questionnaire on Therapeutic Alliance; U: univariate; VW: vocational worker; WAI: Working Alliance Inventory; CC: care coordinator; SU: service user; TR: Therapeutic Relationship; MHS: Mental Health Services; DR: Doctor.

Appendix C SR2: Service delivery/use and adherence associations of TR

Predictor	Author	TR Rater	TR Scale	TR Time	Predictor Time	Scale	Test	Significant findings	NS findings
% of needs met	Catty	SU	HAS	6 months into trial	baseline	CAN	U/MV	$p < 0.01 / -0.05, -0.09$ to 0.00	
		SU	HAS	12 and 18 months	6 months prior	CAN	U/MV	$p < 0.01 / 0.03, 0.01$ to $0.05, p = 0.03$	
		VW	HAS	6 months into trial	baseline	CAN	U/MV	UV: $p < 0.01$	MV: not reported
		VW	HAS	12 and 18 months	6 months prior	CAN	U/MV		not reported
Decision participation	Hamann	SU	QTA	Before discharge	Same	Actual part.	U	$r = 0.262, p < 0.01$	
		DR	QTA	Before discharge	Same	Actual part	U	$r = 0.448, p < 0.01$	
		SU	QTA	Before discharge	Same	Preference	U	$r = -0.173, p < 0.01$	
		DR	QTA	Before discharge	Same	Preference	U		$r = -0.028$
Length of relationships	Catty	SU	HAS	12 and 18 months	6 months prior	months	U/MV		not reported
		VW	HAS	12 and 18 months	6 months prior	months	U/MV	$p < 0.01 / -0.04, -0.07$ to $-0.01, p = 0.003$	
Coercion	Angel	SU	WRS - Bond	cross sectional	same	Leverage	MV		MV: not reported
		SU	WRS - Conflict	cross sectional	same		MV	Beta = $8.51, p = 0.04$	
Communication	Sheehan	SU	HAS	cross sectional	same	Perceived coercion	U	$z = -3.90, p = 0.001$	
	Themistocleous	DR	HAS	cross sectional	same	repair - DR	U	$\rho = 0.689, p = 0.019$	
		DR	HAS	cross sectional	same	repair - SU	U		not reported

Abbreviations: CAN: Camberwell Assessment of Needs; TR: Therapeutic Relationship; HAS: Helping Alliance Scale; MV: multivariate; Part: participation; U: univariate; VW: vocational worker; WAT: Working Alliance Inventory; WRS: working relationship scale; DR: doctor; SU: service user; QTA: Questionnaire on Therapeutic Alliance.

Appendix C (continued)...

Predictor	Author	TR Rater	TR Scale	TR Time	Predictor Time	Scale	Test	Significant findings	NS findings
Assistance with ADL	Calsyn	SU	WAI	3 months	same	ADL	U		r=0.05
		CC	WAI	3 months	same	ADL	U	r=0.24, p<0.01	
Vocational intervention	Catty	SU	HAS	6 months into trial	baseline	Specialist v TAU	U/MV	p<0.01 / 7.64, 5.00 to 10.28	MV: not reported not reported not reported
		SU	HAS	12 and 18 months	6 months prior	Specialist v TAU	U/MV	p<0.01	
		VW	HAS	6 months into trial	baseline	Specialist v TAU	U/MV		
		VW	HAS	12 and 18 months	6 months prior	Specialist v TAU	U/MV		
Counselling	Calsyn	CC	WAI	3 months	same		U		r=0.07
Help seeking		SU	WAI	3 months	same		U		r=0.03
	Calsyn	CC	WAI	3 months	same		U		r=0.11
		SU	WAI	3 months	same		U	r=0.23, p<0.01	
Program Contacts	Calsyn	CC	WAI	3 months	same		U	r=0.33, p<0.001	
		SU	WAI	3 months	same		U		r=0.08
Readiness to change	Calsyn	CC	WAI	3 months	same		U	r=0.20, p<0.05	
		SU	WAI	3 months	same		U	r = 0.24, p<0.01	
Transport	Calsyn	CC	WAI	3 months	same		U	r=0.38, p<0.001	
		SU	WAI	3 months	same		U		r=0.14
Tx Adherence	Corriss	CC	WAI	0.5 months	same	WAI-bond:	U	r=0.24, p<0.05	
		CC	WAI	0.5 months	same	WAI-goal:	U	r=0.28, p<0.05	
		CC	WAI	0.5 months	same	WAI-task:	U	r=0.30, p<0.05	
Mx Adherence	Lecomte	SU	WAI	Baseline	same	Engagement	M	Beta = -0.28, p<0.01	
	Corriss	CC	WAI	0.5 months	same	WAI-bond:	U		r=0.23, NS
		CC	WAI	0.5 months	same	WAI-goal	U	r=0.26, P<0.05	
		CC	WAI	0.5 months	same	WAI-task	U	r=0.36, p<0.05	
	Lecomte	SU	WAI	Baseline	same	WAI total	U		F=1.22, NS

Abbreviations: ADL: activities of daily living; HAS: Helping Alliance Scale; MV: multivariate; Mx: Medication; TAU: treatment as usual; Tx: Treatment; U: univariate; VW: vocational worker; WAI: Working Alliance Inventory ; SU: service user; CC: care coordinator.

Appendix D SR2: Symptom associations of TR

Predictor	Author	Rater of TR	TR Scale	TR Time (mths)	Predictor Time (mths)	Scale	Test	Significant findings	Not significant findings
Diagnosis	Calsyn	SU	WAI	3 months	same		U		r=-0.15
		CC	WAI	3 months	same		U		r=-0.13;
	Catty	SU	HAS	6 months into trial	baseline	OPCRIT	U/MV		not reported
		VW	HAS	6 months into trial	baseline	OPCRIT	U/MV		not reported
Overall	McCabe	SU	HAS	first admission	same	BPRS	U/MV	r= - 0.40, p<0.01	
		SU	HAS	Hospitalised 1.5 years	same	BPRS	U		r= - 0.18
		SU	HAS	Discharged 1.5 years	same	BPRS	U	r= - 0.32, p<0.05	
	Hamann	SU	QTA	Before discharge	Same	BPRS	U	r= - 0.198, p<0.01	
		DR	QTA	Before discharge	Same	BPRS	U	r= - 0.442, p<0.01	
	Bourdeau	SU	WAI	< 2years in Tx	same	BPRS	M		not reported
	Calsyn	SU	WAI	3months	same	BPRS	U		r=-0.12
		CC	WAI	3months	same	BPRS	U		r=0.02
	Catty	SU	HAS	6 months into trial	baseline	PANSS	U/MV		not reported
		SU	HAS	12 and 18 months	6 months prior	PANSS	U/MV		not reported
		VW	HAS	6 months into trial	baseline	PANSS	U/MV	Univariate: p<0.01	MV - not reported
		VW	HAS	12 and 18 months	6 months prior	PANSS	U/MV		not reported
Self-rated	Neale	SU	WAI	24	Same	BPRS	MV	Beta = -0.08, NS	
		CC	WAI	24	same	BPRS	MV	Beta = -0.20, p<0.05	
	McCabe	SU	HAS	first admission	same		U/MV		r= - 0.19
		SU	HAS	Hospitalised 1.5 years	same		U/MV	r= - 0.37, p<0.01/ B = - 0.37, p<0.01	
		SU	HAS	Discharged 1.5 years	same		U/MV		r = - 0.04

Abbreviations: BPRS: Brief Psychiatric Rating Scale; MV: multivariate; mths: months; PANSS: Positive and Negative Symptom Scale;; QTA: Questionnaire on Therapeutic Alliance; SU: service user; TR: Therapeutic Relationships; U: Univariate; U/MV: univariate and multivariate; VW: vocational worker, CC: care coordinator; HAS: Helping Alliance Scale; WAI: Working Alliance Inventory; OPCRIT: diagnostic tool.

Appendix D (continued)...

Predictor	Author	Rater of TR	TR Scale	TR Time (mths)	Predictor Time (mths)	Scale	Test	Significant findings	Not significant findings
Anxiety	Catty	SU	HAS	6 months into trial	Baseline	ADS	U/MV		not reported
		SU	HAS	12 and 18 months	6 months prior	ADS	U/MV		not reported
		VW	HAS	6 months into trial	Baseline	ADS	U/MV		not reported
		VW	HAS	12 and 18 months	6 months prior	ADS	U/MV	p<.01/ 0.23, 0.05 to 0.41, p= 0.012	
Anxiety and Depression	McCabe	SU	HAS	first admission	Same	BPRS	U/MV	r=-0.25, p<0.05;	MV - not reported
		SU	HAS	Hospitalised 1.5 yrs	Same	BPRS	U/MV		r= - 0.19
		SU	HAS	Discharged 1.5 yrs	Same	BPRS	U/MV	r= - 0.45, p<0.01	MV - not reported
		Bourdeau	WAI	< 2years in Tx	Same	BPRS	MV		not reported
Depression	Catty	SU	HAS	6 months into trial	baseline	ADS	U/MV		not reported
		SU	HAS	12 and 18 months	6 months prior	ADS	U/MV		not reported
		VW	HAS	6 months into trial	baseline	ADS	U/MV		not reported
		VW	HAS	12 and 18 months	6 months prior	ADS	U/MV		not reported
Self-Report	Tyrell	SU	WAI	Cross sectional	Same	BDI	U	r= - 0.40, p<0.01	
Activity	McCabe	SU	HAS	first admission	Same	BPRS	U/MV	r= - 0.27, p<0.01	MV - not reported
		SU	HAS	Hospitalised 1.5 yrs	Same	BPRS	U/MV		r= - 0.08
		SU	HAS	Discharged 1.5 yrs	Same	BPRS	U/MV		r= - 0.09
		SU	HAS	first admission	Same	BPRS	U/MV	r = - 0.25, p<0.05	MV - not reported
Anergia	McCabe	SU	HAS	Hospitalised 1.5 yrs	Same	BPRS	U/MV		r= - 0.12
		SU	HAS	Discharged 1.5 yrs	Same	BPRS	U/MV		r= - 0.02
		SU	HAS	first admission	Same	BPRS	U/MV	r- - 0.22, p<0.01	MV - not reported
		SU	HAS	Hospitalised 1.5 yrs	Same	BPRS	U/MV	r= - 0.32, p<0.01	MV - not reported
Hostility	McCabe	SU	HAS	Discharged 1.5 yrs	Same	BPRS	U/MV	r= - 0.51, p<0.01/ B= - 0.55, p<0.001	
		SU	HAS	Discharged 1.5 yrs	Same	BPRS	U		r=-0.12
		Calsyn	WAI	3months	same		U		r= -0.08
		Calsyn	WAI	3months	same		U		
Thought Disturbance	McCabe	SU	HAS	first admission	same	BPRS	U/MV	r= - 0.35, p<0.01; / B=- 0.37, p<0.0001	
		SU	HAS	Hospitalised 1.5 yrs	same	BPRS	U/MV		r= - 0.02
		SU	HAS	Discharged 1.5 yrs	same	BPRS	U/MV		r= - 0.03
		CC	WAI	6 months into trial	same	Trauma hx	U		r= 0.10
Trauma	Picken	CC	WAI	6 months into trial	same	PTSD	U		r= - 0.02
		CC	WAI	6 months into Tx	same	BPRS	MV		not reported
		Bourdeau	WAI	< 2years in Tx	same	BPRS	MV		not reported
		Bourdeau	WAI	< 2years in Tx	same	BPRS	MV		not reported

Abbreviations: ADS: Anxiety and Depression Scale; BPRS: Brief Psychiatric Rating Scale; hx: history; MV:multivariate; mths: months; PTSD: Post Traumatic Stress Disorder; SU: service user; sxs: symptoms; TR: Therapeutic Relationships; Tx: treatment; U: Univariate; U/MV: univariate and multivariate; VW: vocational worker, CM: case manager; HAS: Helping Alliance Scale; WAI: Working Alliance Inventory.

Appendix E SR2: Functioning Associations of TR

	Author	Rated of TR	TR Scale	TR Time (mths)	Predictor Time (mths)	Scale	Test	Significant findings	Not significant findings
Global functioning	Neale	SU	WAI	24	Same	GAF	U	r = 0.36 p<.001	r=0.11, NS
		CC	WAI	24	Same	GAF	U		
		SU	WAI	24	Same	Community living skills	U		r=0.02, NS
		CC	WAI	24	Same	Community living skills	U	r=0.23, p<0.01	
	Tyrell	SU	WAI	cross sectional	Same	GAF	U	r=0.37, p<0.01	
	Catty	SU	HAS	6 months into trial	Baseline	GAF	U/MV		not reported
		SU	HAS	12 and 18 months	6 months prior	GAF	U/MV		not reported
		VW	HAS	6 months into trial	Baseline	GAF	U/MV	: p<0.01	MV: not reported
		VW	HAS	12 and 18 months	6 months prior	GAF	U/MV		not reported
	Angel	SU	WRS - Bond	cross sectional	Same	Payeeship	M		not reported
Social functioning:		SU	WRS - Conflict	cross sectional	Same	Payeeship	M	B=7.08, p=0.04	Adjust leverage: B=4.70, p=0.18
	Bourdeau	SU	WAI	< 2years in Tx	Same	Leisure activities	M	B = 0.322, p<0.05	
		SU	WAI	< 2years in Tx	Same	Relationships - conflict	M	B=0.254, p<0.05	
	Calsyn	SU	WAI	3months	Same	Relationships - conflict	U		r=-0.02
	Catty	SU	HAS	6 months into trial	Baseline	social disability	U/MV		not reported
	Calsyn	CM	WAI	3months	Same	Relationships - conflict	U		r=0.04
	Catty	SU	HAS	12 and 18 months	6 months prior	social disability	U/MV		not reported
	Tyrell	SU	WAI	cross sectional	Same	Global life satisfaction	U	r=0.35, p<0.01	
	Catty	VW	HAS	6 months into trial	Baseline	Self-esteem	U/MV		not reported
		VW	HAS	12 and 18 months	6 months prior	Self-esteem	U/MV		not reported
	Tyrell	SU	WAI	cross sectional	Same	Relationship QOL	U		R=0.09
		SU	WAI	cross sectional	Same	Relationship satisfaction	U	r=0.50, p<0.01	
						social disability		p<0.01/ -0.55, -0.93 to -0.17	
	Catty	VW	HAS	6 months into trial	Baseline	social disability	U/MV		
		VW	HAS	12 and 18 months	6 months prior	social disability	U/MV		not reported

Abbreviations: TR: Therapeutic Relationships; U: univariate; U/MV: univariate and multivariate; MV: multivariate; SU: service user; VW: vocational worker, CM: case manager; CC: care coordinator; HAS: Helping Alliance Scale; WAI: Working Alliance Inventory; GAF: Global Assessment of Functioning.

Appendix E (continued)...

	Author	Rater of TR	TR Scale	TR Time (mths)	Predictor Time (mths)	Scale	Test	Significant findings	Non-significant findings
Vocational Functioning	Calsyn	SU	WAI	3months	Same	Income	U		r = -0.12
		CC	WAI	3months	Same	Income	U	r = - 0.17, p<0.05	
	Catty	SU	HAS	6 months into trial	Baseline	Work history	U/MV	p<.01/ -2.65, -5.28 to -0.03	
		SU	HAS	12 and 18 months	6 months prior	Work history	U/MV		not reported
		VW	HAS	6 months into trial	Baseline	Work history	U/MV		not reported
		VW	HAS	12 and 18 months	6 months prior	Work history	U/MV		not reported

Abbreviations: TR: Therapeutic Relationships; U: univariate; U/MV: univariate and multivariate; MV: multivariate; SU: service user; VW: vocational worker, CC: care coordinator/named clinician; HAS: Helping Alliance Scale; WAI: Working Alliance Inventory.

Appendix F SR2: Other associations with TR

Predictor	Author	Rater of TR	TR Scale	TR Time (mths)	Predictor Time (mths)	Scale	Test	Significant findings	Non-significant findings
Hospitalisation	Prince	CC	PSR	Discharged 3 days	Lifetime	lifetime history	U	t= - 2.21, p<0.05	
	Tyrell	SU	WAI	cross sectional	12 months prior	12 month history	U		r=0.02
	Catty	SU	HAS	6 months into trial	Lifetime	lifetime history	U		not reported
	Catty	VW	HAS	6 months into trial	Lifetime	lifetime history	U		not reported
	Neale	SU	WAI	24	Same	Inpatient days			Beta = 0.07 NS
	Neale	CC	WAI	24	Same	Inpatient days			Beta = 0.04 NS
Quality of Life	McCabe	SU – first SU – first	HAS HAS	B 9	Same Same	Lancashire QOL Lancashire QOL			r=0.10, NS r=0.12, NS
		SU – L	HAS	B	Same	Lancashire QOL		r=0.38, p<0.001 (adjusted)	
		SU – L	HAS	9	Same	Lancashire QOL		r=0.61, p<0.001 (adjusted)	
	Bourdeau	SU	WAI	< 2years in Tx	same	CASIG	M	Beta = -0.327, p<0.05	
	Catty	SU	HAS	6 months into trial	baseline	Lancashire QOL	U/MV		not reported
		VW	HAS	6 months into trial	baseline	Lancashire QOL	U/MV		not reported
		VW	HAS	12 and 18 months	6 months prior	Lancashire QOL	U/MV		not reported
		SU	HAS	12 and 18 months	6 months prior	Lancashire QOL	U/MV		not reported

Abbreviations: TR: Therapeutic Relationships; CC: care coordinator; U: univariate; U/MV: univariate and multivariate; MV: multivariate; SU: service user; SU- first: First admitted sample; SU-L: long-term sample; VW: vocational worker, HAS: Helping Alliance Scale; WAI: Working Alliance Inventory; PSR: Psychotherapy Status Report; QOL: Quality of Life.

Appendix F (continued)...

	Predictor	Author	Rater of TR	TR Scale	TR Time (mths)	Predictor Time (mths)	Scale	Test	Significant findings	Non-significant findings
Other	Clinician Ratings	Hamann	SU	QTA	Before discharge	Same	QTA	U	$r=0.402, p<0.01$	
		Calsyn	SU	WAI	3months	same	WAI	U	$r=0.19, p<0.05$	
		Catty	SU	HAS	6, 12 and 18 months	same	HAS	MV	$1.01, 1.05 \text{ to } 1.15, p=0.001$	
	Attachment	Berry	SU	WAI	cross sectional	same	Anxiety	U/P		$r=-.11, p=.313; r=-.03, p=.769.$
		Berry	CC	WAI	cross sectional	same	Anxiety	U/P	$r=.18, p=.109; r=.24, p=.031$	
		Berry	SU	WAI	cross sectional	same	Avoidance	U/P	$r=-.44, p<.001; r=-.35, p=.02$	
		Berry	CC	WAI	cross sectional	same	Avoidance	U/P	$r=-.33, p=.003; r=-.25, p=.025$	
		Tyrell	SU	WAI	cross sectional	same	Deactivation	U/MV		$r=0.06$
		Tyrell	CM	WAI	cross sectional	same	Deactivation	U/MV		$r=0.07$
	Drug attitudes	Hamann	SU	QTA	Before discharge	Same		U	$r=0.515, p<0.01$	
		Hamann	DR	QTA	Before discharge	Same		U	$r=0.331, p<0.01$	
	F-PAD	Swanson	SU	WAI	1 month	baseline	completion	MV	$\text{Beta} = 0.09, p<0.05$	$\text{beta} = 0.08$
		Hamann	SU	QTA	Before discharge	Same	Insight scale	U		$r = -0.097$
	Insight	Hamann	DR	QTA	Before discharge	Same	Insight scale	U	$r=0.195, p<0.01$	
		Bourdeau	SU	WAI	< 2years in Tx	same	Insight scale	MV	$\text{Beta}=-0.212, p<0.05$	
	Medication practices	Bourdeau	SU	WAI	< 2years in Tx	same	side effects	MV	$\text{Beta} = -0.161 p<0.05$	
		Catty	SU	HAS	6 months into trial	Baseline 6 months prior	Self-esteem	U/MV		not reported
		Catty	SU	HAS	12 and 18 months		Self-esteem	U/MV		not reported

Abbreviations: TR: Therapeutic Relationships; U: univariate; U/MV: univariate and multivariate; MV: multivariate; SU: service user; CM: case manager; HAS: Helping Alliance Scale; WAI: Working Alliance Inventory; QTA: Questionnaire on Therapeutic Alliance; U/P: univariate correlation/partial correlation; Tx: treatment; DR: doctor

Appendix G CIS Papers: Methodology of studies and reason for inclusion

	Authors	Title	Year	Subjects	Methodology	Background of authors	Setting	Reason
1	Priebe et al ¹⁵⁷	Processes of disengagement and engagement in assertive outreach patients: qualitative study.	2005	40 assertive outreach with psychosis	Qualitative: thematic and grounded theory	Psychiatrist; Social Scientists	AOT in London	SU perspectives on mental health treatment; addresses key aspect of relationship: engagement; Influential author; good methodology;
2	Repper et al ¹⁵⁸	How can nurses build trusting relationships with people who have severe and long-term mental health problems?	1994	16 case managers in community and 13 clients	Qualitative	Nurses and social scientists	UK: community	Both SU and case managers as subjects. Examines development of good relationships.
3	Seale et al ¹⁵⁹	Sharing decisions in consultations involving anti-psychotic medication	2006	21 consultant psychiatrists	Qualitative; thematic analysis	Medical sociology; psychiatrists	Outpatient consultants in UK	Psychiatrists as subjects; elements of communication; medication.
4	Mccabe et al ¹⁵⁴	Engagement of patients with psychosis in the consultation: conversational analytic study	2002	32 outpatients with schizophrenia	Conversation analysis	Psychologist; Psychiatrists; Social Scientists	Community outpatient clinics London	Psychiatrists' communication; real examples of interactions.
5	Watts and Priebe ²⁵	Phenomenological account of users experiences of ACT	2002	12 schizophrenia	Qualitative; grounded theory	Social Scientist & Psychiatrist	Assertive Community treatment London	SU experience of assertive treatment; Addresses ethics of treatment.

Abbreviations: AOT: Assertive Outreach Team; UK: United Kingdom; SU: Service user

Appendix G (continued...)

	Authors	Title	Year	Subjects	Methodology	Background of authors	Setting	Reason
6	Neale and Rosenheck ¹⁵⁶	Therapeutic limit setting in ACT	2000	1564 veterans and their case managers	Quantitative; client and contact factors predicting use of limit setting activities	Psychiatrists	VA - Assertive community treatment USA	Influential authors; SU and case managers. Methods of influence
7	Angell and Mahoney ¹⁴⁸	Reconceptualising the case management relationship in Intensive Treatment	2007	Case managers from ICM in urban and rural areas	qualitative - both observation and interviews	Social work/ psychology /case managers	ICM USA	Case managers perspectives from ICM - strong method including observation
8	Lidz et al ¹⁵³	Perceived coercion in mental hospital admission	1995	157 SU admitted (mix diagnoses)	Quantitative; Macarthur Admission Experience Interview	Psychiatrists and psychologists	Two USA state hospitals - Virginia and Pennsylvania	huge citation; SU experience on admission to inpatient; experience of coercion; early paper data 1991
9	Gilburt, et al ¹⁵⁰	The importance of relationships in mental health care	2008	SU admitted	Qualitative	SU and psychologist	UK inpatient setting	SU authors. SU views of inpatient wards effecting views of services and behaviour outside in community

Abbreviations: ACT: Assertive Community Treatment; ICM: Intensive Case Management; SU: Service User; VA: Veterans' Affairs; UK: United Kingdom; USA: United States of America

Appendix G (continued...)

	Authors	Title	Year	Subjects	Methodology	Background of authors	Setting	Reason
10	Mead and Copeland ¹⁵⁵	What recovery means to us	2000	None	Opinion/theoretical	SU	Recovery based approach	SU authors; SU views; influential authors; focus on ways of improving relationships
11	Jackson and Stevenson ¹⁵¹	What do people need psychiatric and mental health nurses for?	2000	SUs, nurses, psychiatrists and other professionals	Qualitative	Nurses	UK	Subjects from multiple backgrounds – clinicians and SU; views on goals of mental health nursing; good method
12	Canvin et al ¹⁴⁹	A 'bittersweet pill to swallow': Learning from mental health SU' responses to compulsory community care in England	2002	20 SU subject to compulsory community treatment	Qualitative	Researchers /psychiatrist	Community UK	SU experience of compulsory treatment
13	Kirsh and Tate ¹⁵²	Developing a comprehensive understanding of the working alliance in CMH	2006	33 interviews from SMI; carers; clinicians; and 48 articles	Literature and qualitative interviews; grounded approach	OT; social work	CMHT; literature from Australia, Canada, USA and UK	SU, carer and clinician perspectives, good method including literature review of themes in TR; authors allied profs

Abbreviations: SU: Service user; OT: Occupational Therapist; CMHT: Community Mental Health Team; CMH: Community Mental Health; TR: Therapeutic Relationship; UK: United Kingdom; USA: United States of America

Appendix H Audit of CPA crisis and contingency plans

	Baseline Yes (%)	Follow-up Yes (%)
1. Care plan has been reviewed in last 12 months	71	78
2. Care plan has been signed by the user	12.5	19
3. Service users are given a copy of their care plan	40.5	44
4. Service users are present (or decline to attend) at all meetings where care plans are agreed	52.4	75
5. Care planning includes relatives/ carers/ neighbours/ friends and agencies who have a role in supporting the service user	20.3	27
6. Care planning includes contingency arrangements for short notice failure in an element of support with the plan	30.4	40
7. Out of hours arrangements are specified	55	40
8. Crisis Plan includes		
8.1. Person who the service user is most responsive to	10	6.6
8.2. how to contact that person	2	2.4
8.3. Previous strategies that have been successful.	9.6	11
8.4. Previous strategies that have NOT been successful	2.1	4.3
8.5. Any treatment preferences or things they do want	4.5	5.6
8.6. Any treatment refusals or things they do NOT want	2.4	2.8

	Baseline %	Follow-up %
9. Relapse indicators		
None identified	30.9	28.0
1 relapse indicator clearly identified	5.9	3.0
2 or more relapse indicators clearly identified	63.2	69.0
10. Crisis Action Plan (excl relapse indicators)		
No crisis plan	28.5	17.4
Crisis plan, but no specific information	56.6	55.7
Crisis plan including one item of specific information	8.5	15.1
Crisis plan including more than one item of specific information	6.1	11.8
Missing	0.2	

Appendix I Joint Crisis Plan Menu

This menu is to help you decide what you would like on your crisis card or joint crisis plan. Some sections can be simply filled in by you if you want them included. Elsewhere you may want to select an item but wait to discuss the details with your treatment team at your crisis planning meeting.

You can include as much or as little information as you wish. Whatever you have chosen or agreed at your crisis planning meeting will then be made up into your own personal card or plan.

It is important that your Crisis Card or Joint Crisis Plan is kept up to date. If you feel that it needs to be updated at any time please contact your treatment team.

Please tick which of the following you would like on your crisis card or plan. Please provide details if at all possible.

- ☐ My name
Address
Tel no.
- ☐ GP's name
Address
Tel no.
- ☐ Consultant's name
Address
Tel no.
- ☐ CPN's name
Address
Tel no.
- ☐ Social Worker's name
Address
Tel no.
- ☐ Other (please name)
Address
Tel no.

If there is someone you would like to be called in a crisis, please tick the following paragraph and ask this person (your nominee) if they would be willing to help and support you in an emergency. This person could be a relative, a friend, or an advocacy worker. It would be helpful to invite them to be present at your crisis planning meeting when you discuss your crisis card or joint crisis plan so that they can understand what you would want done in an emergency.

- ☐ "If I appear to anybody to be experiencing "mental health" difficulties that require decisions to be taken either **against my wishes** or **in the absence of my agreement** then I request that my nominee, below, be contacted immediately, informed of what is happening and requested to attend as a matter of urgency. My nominee is:"

Name
 Address

 Tel no: Home.....Work.....

Current Care and Treatment Plan

Please tick which of the following you would like on your crisis card or plan. You may want to fill in the details yourself or you can discuss them with your treatment team at your crisis planning meeting.

- ☐ **My mental health problem or diagnosis**

- ☐ **Physical illnesses or allergies** eg. diabetes, sickle cell, epilepsy, allergic to penicillin

- ☐ **My Current Care/Treatment Plan** Here you can include details such as regular arrangements to see your psychiatrist, CPN or social worker, plans to attend a day centre, plans for rehousing or for greater support in the community

- ☐ **Current Medication & dosage**

- ☐ **Circumstances that may lead to me becoming unwell or have done in the past** *This may help you, or a relative, friend or nominee to recognise when you are becoming unwell and need help, or help prevent this happening. eg. being on my own at weekends, forgetting to take my medication*

.....
...
.....
.....

- ☐ **What happens when I first start to become unwell** *This may help you, or a relative, friend or nominee to recognise the first signs that you are becoming unwell and need help. eg. not sleeping, becoming restless, feeling suspicious, voices becoming louder*

.....

- ☐ **Treatments or other things that have been helpful during crises or relapses in the past**

.....
.....
.....

- ☐ **Treatments or other things that have not been helpful during crises or relapses in the past**

.....
.....

Care in a Crisis

Here you can make plans in advance for the care or treatment you would prefer in a crisis.

- ☐ **What I would like to be done when I first start to become unwell** *Here you can describe what you want done when you first become unwell, to help prevent you from becoming fully unwell eg. make an appointment to see your keyworker or psychiatrist urgently, start some medication that you know has helped you in the past.*

.....
...
.....
.....

☐ **Preferred treatment or social care during a crisis or relapse**

Here you can describe what you want done if you do become fully unwell. This may be helpful if it is difficult to make decisions for yourself when you are fully unwell.

.....
.....

☐ **Specific refusals regarding treatment during a crisis or relapse**

Here you can describe what you do not want done if you become fully unwell.

.....
.....
.....

☐ **Circumstances in which I would wish to be admitted to hospital for treatment**

This may be useful if you recognise that there are times when it would be helpful to be treated in hospital, but find it difficult to accept that you need this help when you are becoming unwell.

.....
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.....
.....
.....

Practical Help in a Crisis

If you live alone you may wish to have the following tasks undertaken should you have to be admitted to hospital. You will need to give details of who you would like to carry out these tasks and where they can be contacted. You will need to ask their permission, give them information such as the phone numbers to cancel services, and may wish to leave them a spare set of keys to your home in case of an emergency.

☐ **If I am admitted to hospital please contact the person named below and ask them if they would carry out the following tasks for me.**

Name
Address
Tel no: Home.....Work.....

tick whichever are required

- ☐ check my home is secure. ie. doors locked, cooker and fires turned off.
- ☐ dispose of perishable food
- ☐ cancel services eg. milk deliveries, paper deliveries, home help.
- ☐ water plants or garden
- ☐ look after my pet
- ☐ let my work (or college or day centre) know
- ☐ other (please describe the task you need carried out)

.....

- ☐ **If I am admitted to hospital I would like the following arrangements for my children/dependent relative** *If you have young children, or an elderly/disabled relative at home you may want to give details about who you would like to look after them if you are in hospital. For children you may want to say whether you would like them to continue at school, nursery or with the childminder, and what you would like them to be told.*

.....

- ☐ **Other information I would like to be known or taken into account** *eg. special diets, people I would or would not like to be told, people I would or would not like to visit me*

.....

Agencies or people that I would like to have copies of this card or agreement
(please tick)

- ☐ myself
- ☐ treatment team
- ☐ emergency clinic
- ☐ GP
- ☐ my nominee
- ☐ other (please name)

.....

Date of Crisis Planning Meeting

Present at meeting:

Name	Role or profession <i>eg. friend, relative, keyworker/CPN</i>

Appendix J Fictional JCP example

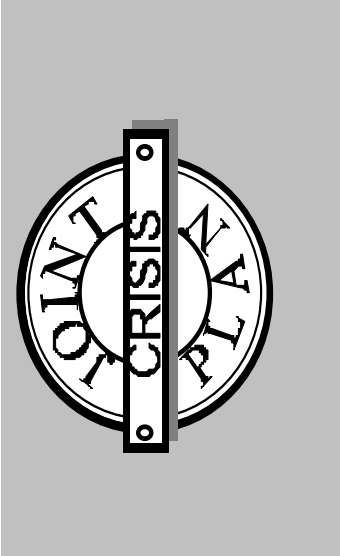
This Joint Crisis Plan has been developed by agreement between Rangini Flood, Melanie de Castro, Dr. Veronica Chinchou and Chris Flood, on 09th July 2008.

Please make every effort to fulfil this agreement in the event of a crisis.

Advance statements regarding preferences for care included in a Joint Crisis Plan are not legally binding. Where a Joint Crisis Plan includes a valid advance refusal of treatment, that specific statement is legally binding, but may be overruled in certain circumstances such as treatment under the Mental Health Act.

Checked by user
Date

© Institute of Psychiatry



My name Rangini Flood
Address 123 Hill Road

Tel No 0207 123 4567

GP Dr. Roberts
Address Herne Hill surgery

Tel No 0208 123 4567

Consultant Dr. Chinchou
Address King's College Hospital

Tel No 0207 848 0714

CPN Mel de Castro
Address Institute of Psychiatry

Tel No 0207 848 5055

If I appear to anybody to be experiencing "mental health" difficulties that require decisions to be taken either **against my wishes or in the absence of my agreement** then I request that my nominee, below, be contacted immediately, informed of what is happening and requested to attend as a matter of urgency. My nominee is :

Name Chris Flood
Address 123 Hill Road
Tel No 0207 123 456

Current Care and Treatment Plan

My mental health problem or diagnosis
I hear voices

My current care/treatment plan
I see my care coordinator once a week
I see Dr. Bisler at regular OPAs

Current Medication & dosage
Risperidone Constal (depot) 37.5mg every two weeks.

Circumstances that may lead to me becoming unwell or have done in the past
Exam stress has previously caused me to become unwell.

What happens when I first start to become unwell
I argue with my sister.
I find it difficult to sleep because of the voices.
I play my music a bit louder when the voices bother me.
I use my sister's makeup.

Treatments or other things that have been helpful during crises or relapses in the past
Going to hospital.
A temporary oral increase in Risperidone (not tablets)

Treatments or other things that have not been helpful during crises or relapses in the past
Not being able to leave hospital when I wanted to go home.

Care in a Crisis

What I would like to be done when I first start to become unwell
I would like increased contact with my care coordinator.
I would like to see a permanent doctor if possible.

Preferred treatment or social care during a crisis or relapse
I would like to go into hospital as an informal patient.

Specific refusals regarding treatment during a crisis – see *legal statement over/leaf*
I don't want to be injected or restrained.

Circumstances in which I would wish to be admitted to hospital for treatment
When arguments at home become too intense and I am not able to cope with my family.

Other information I would like to be known or taken into account
I would like special hospital meals.

Practical Help in a Crisis

If I am admitted to hospital please contact the person named below and ask them if they would carry out the following tasks for me:

Let my work/college/day centre know.

Name Melanie de Castro
Address Institute of Psychiatry
Tel No 0207 848 5055

Agencies or people that have copies of this card or agreement

- Myself
- My treatment team

Appendix K CRIMSON ethics approval confirmation



National Research Ethics Service **King's College Hospital Research Ethics Committee**

Camberwell Building
King's College Hospital
94 Denmark Hill
London
SE5 9RS

Telephone: 0203 299 3923
Facsimile: 0203 299 5085

10 January 2008

Professor Graham Thornicroft
Head of Health Service and Population Research Department
Health Service and Population Research, Institute of Psychiatry
P029, De Crespigny Park, London
SE5 8AF

Dear Professor Thornicroft

Full title of study: CRIMSON Study: RCT of Joint Crisis Plans to Reduce
Compulsory Treatment of People with Psychosis.
REC reference number: 07/H0808/174

Thank you for your letter of 18th December 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>
Application	5.5 dated 31/10/2007
Investigator CV	Prof Graham Thornicroft
Protocol	Version 3, 31st October 2007
Letter from Sponsor	KCL
Peer Review	MRC
Questionnaire	dated 31st October 2007

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Questionnaire	dated 31st October 2007
Questionnaire: Global Assessment of Functioning (GAF) Scale	dated 31st October 2007
Questionnaire: CRIMSON Adult Service Use Schedule (AD-SUS)	dated 31st October 2007
Questionnaire: Sociodemographic	dated 31st October 2007
Letter of invitation to participant	Version 1, dated 31st October 2007
Participant Information Sheet: Service Users	Version 4, dated 31st October 2007
Participant Information Sheet: Staff	Version 4, dated 31st October 2007
Participant Information Sheet	Version 5, 32nd October 2007
Participant Consent Form	Version 4, 18th December 2007
Participant Consent Form: Service Users	Version 2, dated 31st October 2007
Participant Consent Form: Staff	Version, dated 31st October 2007
Response to Request for Further Information	Dated 18 December 2007
MRC Assessment	
MRC Application	
Information Flyer	dated 31st October 2007
MRC Approval	
Response to referee comments	dated 12/05/2006

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from
<http://www.rdforum.nhs.uk/rdform.htm>.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following

- a) Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website.
- b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.


- d) Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- e) End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nationalres.org.uk.

07/H0808/174**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely


Dr David Jewitt
Chair

Email: william.bowen@kch.nhs.uk

Enclosures: *Standard approval conditions*
 Site approval form

Copy to: Ms Gill Lambert SlaM/IoP R&D

Patient Information Sheet**CRIMSON study: A Study of Joint Crisis Plans to reduce compulsory treatment for people with psychosis.**

(Version 5, 31 October 2007)

You are invited to take part in a study of 'Joint Crisis Plans'. The Joint Crisis Plan is an agreement between you and your mental health team about what to do if you become unwell in the future. An independent person (or "facilitator") helps you and the team to reach agreement and makes sure that your voice is heard.

This information sheet is to help you decide if you want to take part. Please read it carefully. Feel free to discuss the study with friends, relatives or staff.

What is the purpose of the study?

We want to find out if people who have a Joint Crisis Plan are less likely to be admitted to hospital against their will (in other words 'sectioned' under the Mental Health Act). We would also like to know if they are happier with their treatment, and feel more involved in their care. We also want to know if people with Joint Crisis Plans get on better with mental health staff.

The best way to find this out is to conduct a trial and compare what happens to two groups of people, one with the Joint Crisis Plan and another without.

Why have I been invited?

We want you to take part because you have been admitted to hospital due to mental health problems.

Do I have to take part?

No. If you decide not to take part, your care will not change in any way. Even if you decide to take part, you may leave the study at any time, without giving a reason.

What will happen if I choose to take part?

To make sure the Joint Crisis Plan is effective we wish to compare two groups. The first group will have a Joint Crisis Plan and the second ("control") group will not. To make sure this comparison is fair, and the groups are similar, a computer will decide which group you are in at random. You will have a fifty-fifty chance of being in the group with the Joint Crisis Plan.

If you take part in the study, you will be interviewed twice. The first interview will be as soon as you agree to take part. The second will be 18 months later. Each interview will take one hour. You will be asked questions about your treatment and how you get along with your mental health team. The answers you give will be confidential to the study and will not be shared with your mental health team. The interviewer will read your medical records to check your diagnosis and history of admissions, and may also contact your GP or mental health care team to check your contact details. At the end of each interview you will be given £20 as a thank-you for the time and thought you have given to this study.

Control Group:

If you are in the Control Group, you will not make a Joint Crisis Plan and your treatment will continue as normal.

Joint Crisis Plan Group:

If you are in the Joint Crisis Plan group, then as well as being interviewed, you will have two meetings to develop your Joint Crisis Plan. You may also be asked to attend a discussion group.

At the first meeting: An independent person ("the facilitator") will meet with you and your care coordinator for half an hour to discuss what you might want on the Joint Crisis Plan. This could include information about what treatment has been helpful and what has not, and what you would like to happen if you become unwell in the future. If you have already made an advance decision¹ this can be incorporated into your Joint Crisis Plan.

At the second meeting: The facilitator will meet with you and your care coordinator and psychiatrist. You will be encouraged to bring a relative or friend. This meeting will take one hour and will give you an opportunity to discuss what you would like to happen if you were to have a mental health crisis. If your treatment team does not agree with your wishes (e.g. with any medication refusals you may make), they will be asked to explain why, and to suggest other options. The facilitator will be there to help the discussion, and to ensure that what is included on your Joint Crisis Plan is your choice. These meetings will be audio taped so that we can make sure that everyone is getting the same amount of help.

Once the plan has been finalised with you, the facilitator will send a copy of your Joint Crisis Plan to you, and everyone you would like to have a copy. Your treatment team will endeavour, but can not guarantee, to follow the agreement reached, for example in situations when the Mental Health Act is used. During the study the Joint Crisis Plan can be updated if necessary. As this is your plan, you may withdraw your Joint Crisis Plan at any time or keep it even after the study finishes.

If your team is unable to agree with an aspect of your plan, we could still complete a plan for you, but it will be a statement of your treatment preferences or wishes which we call a 'Crisis Card'. If you become unwell again this 'Crisis Card' would remind your treatment team of your wishes, and would carry some weight, however the team would not have to follow your wishes.

Discussion Group: About 1 in 5 people will be asked to take part in a discussion group about the Joint Crisis Plan. The discussion will help the researchers to understand what worked and didn't work with Joint Crisis Plans. The discussions will be audio-taped, but will be kept confidential and used only for research purposes.

¹ Recent legislation, the Mental Capacity Act 2005, means that patients may make 'advance decisions' setting out treatment refusals which must be respected unless the Mental Health Act is used to override a person's wishes. Other treatment preferences can also be stated but do not carry the same force of law. Your Trust can provide you with information about this. A Joint Crisis Plan differs from an 'advance decision' in being an *agreement* between you and your treatment team about what should happen. The Joint Crisis Plan may be able to include what you would have chosen to put in an 'advance decision'.

Each group member will be paid £20 to thank them for their time. You can take part in the study but refuse to take part in the group discussion.

What are the possible risks of taking part?

You could find it upsetting to discuss your experiences of mental illness and treatment. If this happens you can ask for the meeting or interview to stop, and we will make sure you receive support. The meeting can then be rearranged if you wish.

You might be worried that someone could find and read your Joint Crisis Plan. If you are worried about this we can help you find a safe place to keep it, or make sure that only your care team has a copy. We will take very careful precautions, to make sure that your confidential information is not disclosed outside the study.

What are the possible benefits of taking part?

You may or may not experience some benefit from taking part in this research. The Joint Crisis Plan may provide important information about you during a crisis or relapse. Previous research suggests that people with Joint Crisis Plans are less likely to be "sectioned", but we do not know this for certain.

What if there are any problems?

If you are worried about any part of this study, please speak to the researchers who will do their best to answer your questions (contact details below). If you have complaints about the study you can complain formally through the NHS Complaints Procedure (details can be obtained from the Trust).

Will my taking part in the study be kept confidential?

All information collected about you will be kept strictly confidential to the study (unless it gives rise to concerns about your safety or that of other people). Any information about you that we store on computer will have your name and address removed so that you cannot be recognised. Written records of interviews will be stored in locked files in the researchers' office. All databases will be password protected. Information collected in the study will only be available to research staff and research regulators.

What will happen to the findings of the study?

Results from the study may be published in medical or psychiatric journals, without the use of any information that could identify individual patients. We will send you information about the study once it has finished.

Who is organising and funding the research?

This research is being run and organised by three groups: the Institute of Psychiatry, Kings College London; the University of Birmingham; and the University of Manchester. The research is funded by the Medical Research Council (MRC).

Who has approved the study?

This study has been reviewed and given favourable opinion by Kings College Hospital Research Ethics Committee.

Further information and contact details

If you have any questions regarding the study, you can contact Professor Graham Thornicroft (Chief Investigator) on 0207 848 0735 or Ms. Simone Farrelly (Scientific Coordinator) on 0207 848 5098.

You may also contact your local site lead.

- Dr George Szukler for London site on 0207 848 0096
- Professor Max Birchwood for Birmingham site on 0121 301 1850
- Professor Max Marshall for Manchester site on 01772 773500

CONSENT FORM
**CRIMSON study : A Study of Joint Crisis Plans to reduce compulsory treatment
for people with psychosis.**
(Version 4, 18 December 2007)

Centre number:

Patient Identification number for this study:

Please tick each box

- | | |
|--|--------------------------|
| 1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my medical care or legal rights being affected. | <input type="checkbox"/> |
| 3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by in the study team. I give permission for these individuals to have access to my records. | <input type="checkbox"/> |
| 4. <u>I understand that my GP may be contacted to inform them of my participation in this study. I give permission for this.</u> | <input type="checkbox"/> |
| 5. I understand that interviews and JCP facilitation sessions may be tape recorded | <input type="checkbox"/> |
| 6. I agree to take part in the above study | <input type="checkbox"/> |

_____ Name of Participant	_____ Date	_____ Signature
_____ Name of Person taking consent (if different from researcher)	_____ Date	_____ Signature
_____ Name of Researcher	_____ Date	_____ Signature

When completed, 1 for patient; 1 for researcher site file; 1 (original) to be kept in medical notes

Information Sheet
CRIMSON study: A Study of Joint Crisis Plans to reduce compulsory treatment
for people with psychosis.
For Staff
(Version 1, 09 April 2008)

We would like to invite you to take part in the CRIMSON study. Before you decide you need to understand why CRIMSON is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about CRIMSON if you wish.

Ask us if there is anything that is not clear or if you would like more information – there are contact details at the end of page 2. Take time to decide whether or not you wish to take part.

You are invited to take part in a study of 'Joint Crisis Plans'. The Joint Crisis Plan is an agreement between a service user and their mental health team about what to do if the service user becomes unwell in the future. An independent person (or "facilitator") helps the service user and the team to reach agreement and makes sure that all voices are heard.

This information sheet is to help you decide if you want to take part. Please read it carefully. Feel free to discuss the study with friends, relatives or staff.

What is the purpose of the study?

We want to find out if people who have a Joint Crisis Plan are less likely to be 'sectioned' under the Mental Health Act. We would also like to know if they are happier with their treatment, and feel more involved in their care. We also want to know if people with Joint Crisis Plans get on better with mental health staff. The best way to find this out is to conduct a trial and compare what happens to two groups of people, one with the Joint Crisis Plan and another without.

Why have I been invited?

We want you to take part because you are a care co-ordinator for a service user that has agreed to take part in the study. We are interested in your relationship with the service user and would like to look at factors that may affect this relationship.

Do I have to take part?

No. If you decide not to take part, your rights will not change in any way. Even if you decide to take part, you may leave the study at any time, without giving a reason.

What will happen if I choose to take part?

To make sure the Joint Crisis Plan is effective we wish to compare two groups. The first group will have a Joint Crisis Plan and the second ("control") group will not. Once a service user and their care coordinator agree to take part, the service user will be placed in one of these two groups. To make sure this comparison is fair, and the groups are similar, a computer will decide which group the service user is in at random. They will have a fifty-fifty chance of being in the group with the Joint Crisis Plan.

If you take part in the study, you will be interviewed twice. The first interview will be as soon as you agree to take part. The second will be 18 months later. Each interview will take a maximum of 20 minutes. You will be asked some basic demographic questions, and be asked to complete two questionnaires regarding your relationship with the service user involved in CRIMSON. The answers you give will be confidential to the study and will not be shared with the service user.

Control Group:

If the CRIMSON participant you work with is in the Control group, he/she will not make a Joint Crisis Plan and treatment will continue as normal.

Joint Crisis Plan Group:

If the service user you work with is in the Joint Crisis Plan group, then as well as being interviewed, you will have two meetings to develop his/her Joint Crisis Plan. You may also be asked to attend a discussion group.

At the first meeting: An independent person ("the facilitator") will meet with you and the service user for half an hour to discuss what the service user might want on the Joint Crisis Plan. This could include information about what treatment has been helpful and what has not, and what he/she would like to happen in the event of a future crisis. If the service user already has an advance decision² this can be incorporated into your Joint Crisis Plan.

At the second meeting: The facilitator will meet with you and the service user and psychiatrist. This meeting will take one hour and will give the service user an opportunity to discuss what they would like to happen if they were to have a mental health crisis. If you do not agree with the service user's wishes (e.g. with any medication refusals that may be made), you will be asked to explain why, and to suggest other options. The facilitator will be there to help the discussion, and to ensure that what is included on the Joint Crisis Plan is of the service user's choice. These meetings will be audio taped so that we can make sure that everyone is getting the same amount of help.

Once the plan has been finalised, the facilitator will send a copy of the Joint Crisis Plan to you, if agreed by the service user. You and the treatment team should then endeavour to follow the agreement reached. However, the service user will be informed that there may be situations in which the team may not follow the agreement, for example in situations when the Mental Health Act is used. During the study the Joint Crisis Plan can be updated if necessary. If the group is unable to agree with an aspect of the plan, a plan could still be completed, but it will be a statement of treatment preferences or wishes which we call a 'Crisis Card'. If the service user then becomes unwell again this 'Crisis Card' would remind the treatment team of the service user's wishes, and would carry some weight, however the team would not have to follow these wishes.

² Recent legislation, the Mental Capacity Act 2005, means that patients may make '*advance decisions*' setting out treatment refusals which must be respected unless the Mental Health Act is used to override a person's wishes. Other treatment preferences can also be stated but do not carry the same force of law. Your Trust can provide you with information about this. A Joint Crisis Plan differs from an 'advance decision' in being an *agreement* between you and your treatment team about what should happen. The Joint Crisis Plan may be able to include what you would have chosen to put in an 'advance decision'.

Discussion Group: About 1 in 5 service users and their care coordinators will be asked to take part in discussion groups about the Joint Crisis Plan. The discussion will help the researchers to understand what worked and didn't work with Joint Crisis Plans. You will therefore only be invited to participate in these groups if a service user you are working with is in the intervention group and develops a Joint Crisis Plan. If you are invited, there will be two separate groups: one with other care coordinators and a combined group of service users and care coordinators. The discussions will be audio-taped, but will be kept confidential and used only for research purposes. Each group member will be paid £20 to thank them for their time. You can take part in the study but refuse to take part in the group discussion.

What are the possible risks of taking part?

There are no foreseeable risks to taking part in the study.

What are the possible benefits of taking part?

You may or may not experience some benefit from taking part in this research. The Joint Crisis Plan discussions may improve your relationship with the service user.

What if there are any problems?

If you are worried about any part of this study, please speak to the researchers who will do their best to answer your questions (contact details below). If you have complaints about the study you can complain formally through the NHS Complaints Procedure (details can be obtained from the Trust).

Will my taking part in the study be kept confidential?

All information collected about you will be kept strictly confidential to the study (unless it gives rise to concerns about your safety or that of other people). Any information about you that we store on computer will have your name and address removed so that you cannot be recognised. Written records of interviews will be stored in locked files in the researchers' office. All databases will be password protected. Information collected in the study will only be available to research staff and research regulators.

What will happen to the findings of the study?

Results from the study may be published in medical or psychiatric journals, without the use of any information that could identify individuals. We will send you information about the study once it has finished.

Who is organising and funding the research?

This research is being run and organised by three groups: the Institute of Psychiatry, Kings College London; the University of Birmingham; and the University of Manchester. The research is funded by the Medical Research Council (MRC).

Who has approved the study?

This study has been reviewed and given favourable opinion by Kings College Hospital Research Ethics Committee.

Further information and contact details

If you have any questions regarding the study, you can contact Professor Graham Thornicroft (Chief Investigator) on 0207 848 0735 or Ms. Simone Farrelly (Scientific Coordinator) on 0207 848 5098.

You may also contact your local site lead.

- Dr George Szmukler for London site on 0207 848 0096
- Professor Max Birchwood for Birmingham site on 0121 301 1850
- Professor Max Marshall for Manchester site on 01772 773500

CONSENT FORM
CRIMSON Study: A Study of Joint Crisis Plans to reduce compulsory treatment
for people with psychosis.
Staff
(Version 2, 29 July 2009)

Centre number:
Participant Identification number for this study:

Please tick each box

- | | |
|--|--------------------------|
| 1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my medical care or legal rights being affected. | <input type="checkbox"/> |
| 3. I understand that interviews and JCP facilitation sessions may be tape recorded | <input type="checkbox"/> |
| 4. I agree to take part in the above study | <input type="checkbox"/> |

_____ Name of Participant/Staff Member	_____ Date	_____ Signature
_____ Name of Person taking consent (if different from researcher)	_____ Date	_____ Signature
_____ Name of Researcher	_____ Date	_____ Signature

When completed, 1 for participant; 1 for researcher site file; 1 (original)

Appendix M Quality rating of Joint Crisis Plan

1. Under the section for contact details that can include the user, team, GP and nominee

N/A	Section not included at service user's request (user's name is required as a minimum)
0	Sub-headings/titles present but no details in one or more
1	Contact details are present for all chosen headings but incomplete (e.g., no phone numbers)/ incorrect/typos
2	Contact details for chosen headings are complete and correct

2. Current Care and Treatment Plan

N/A	Section and heading not included at service user's request
0	Sub- headings present but no details in one or more
1	Information misleading (misspelled/unclear/incomplete/typos)
2	Clear information – no errors

3. Care in a Crisis

N/A	Section and heading not included at service user's request
0	Sub-headings present but no details in one or more
1	Information present but is misleading (i.e., misspelled/ unclear/typos / incomplete e.g., – Advance Statement/Decision is noted on plan but not in this section)
2	Clear information – no errors

4. Practical Help in a Crisis

N/A	Section and heading not included at service user's request
0	Sub-heading (s) present but no details in one or more
1	Information present but misleading (i.e., misspelled/ unclear/ incomplete (e.g., no phone numbers)/typos)
2	Clear information - no errors

5. Under the section 'This Joint Crisis Plan has been developed by agreement between:'

N/A	Section removed as re-named a Crisis Card
0	Section not completed
1	One or more names are misspelled/ incomplete, e.g. no relationship to service user noted, first name only, or date missing
2	Names and date completed and correct (including relationship to service user)

6. The Joint Crisis Plan is completed in the first person wording of the user ie. "I would like..." throughout the Joint Crisis Plan

0	Two or more references to the user in the third/second person
1	One reference to the user in the third/second person
2	No references to the user in the third/second person (first person throughout)

7. Technical language is translated into lay language wherever possible eg. Dosages of medications are recorded as twice daily rather than BD.

0	Technical language used in 2 or more sections
1	Technical language used in one section
2	No technical language – written to be understood by the lay reader

Appendix N JCP Fidelity A – Preparatory meeting

1. The user has an initial meeting with the facilitator where they are provided with an adequate explanation of the nature of the Joint Crisis Plan, and the process of development, including the point that the content of the JCP will be the service user's choice

0	Explanation failed to cover key points or was confusing/misleading
1	Explanation covered the main issues, but was rushed or questions not answered
2	An adequate and clear explanation was provided and questions answered

2. The facilitator addresses the legal standing of Joint Crisis Plans and answers any further questions about legal issues relating to JCPs clearly and accurately

0	The facilitator does mention any legal issues, or does so in a way that is seriously misleading or inaccurate
1	The facilitator addresses legal issues and/or answers questions but their responses lack clarity/ are confusing
2	The facilitator answers clearly and accurately

3. The initial meeting takes place with sufficient time before the Joint Crisis Planning meeting to allow the user to prepare.

0	Initial meeting took place the same day as the planning meeting
1	Initial meeting took place the day before the planning meeting
2	The process of setting up the Joint Crisis Planning meeting begins after the initial meeting has taken place, or at least 2 or more days apart

4. The care coordinator is present at the initial meeting and is enabled to become involved in helping or offering to help support the user think about the content of their JCP

N/A	No care coordinator or care coordinator allocated
0	Care coordinator not present
1	Care coordinator present but not involved in a constructive or supportive fashion
2	Care coordinator present and involved in discussion at least once in a constructive or supportive fashion

5. The user is encouraged to invite an advocate, friend or family member to the planning meeting if they think that this would be helpful for them.

0	The user was discouraged from inviting an advocate, friend or family member to the planning meeting
1	The user was instructed to invite an advocate, friend or family member to the planning meeting
2	The user was encouraged to consider inviting an advocate, friend or family member to the planning meeting .

6. Efforts were made to accommodate the availability of the user and the advocate/friend/family in arranging the Joint Crisis Planning meeting.

0	The facilitator did not ask about the availability of the user
1	The facilitator checked the user's availability only
2	The facilitator checked the user's availability and offered to try to accommodate the advocate/friend/family member if planning to attend

7. The facilitator introduces and gives the user a copy of the menu of options, talking through the main sections with some explanation of their purpose

0	No explanation of the what the menu is for/not given a menu
1	Some explanation of how the menu is to prepare for the JCP planning meeting, but no explanation of the purpose of specific items or nominee
2	Good explanation of the general purpose of the menu and the purpose of specific items given as examples

8. . The facilitator establishes a good rapport, and responds with empathy to the user's comments and questions throughout the initial meeting, in a way that would give the user confidence that their views and preferences would be listened to and their choices respected in a Joint Crisis Planning meeting ?

0	Minimal degree of rapport, empathy and understanding
1	Fair degree of rapport, empathy and understanding
2	Good degree of rapport, empathy and understanding

Appendix O JCP Fidelity Scale B – Planning meeting

1. The facilitator begins by explaining the purpose of the meeting, the nature of the Joint Crisis Plan, the roles of those present, and includes the point that the content of the JCP will be the service user's choice.

0	No initial explanation/introduction
1	Partial or unclear explanation and introduction
2	Adequate and clear explanation and introduction

2. Meetings include as a minimum the user, a medical member of the treating team, and a facilitator.

0	No medical member of the treating team was present
1	A medical member was present but was not the usual treating provider OR was unfamiliar with the user's case OR expressed concerns about being able to answer queries due to inexperience/lack of knowledge of the patient.
2	A medical member of the treating team was present who was the usual treating provider and/or was familiar with the user's case

3. The facilitator is independent of and is not a member of the treating team.

0	No independence: the facilitator was one of the user's regular providers
1	Intermediate independence: the facilitator was a member of the team but not a regular provider
2	Full independence: the facilitator was independent of and not a member of the treating team.

4. The facilitator provides structure to the meeting by reading through each section of the menu, providing an explanation of the purpose and pausing to check whether the user wants to include information/statements and allowing time for discussion if required

0	No structure to meeting/no explanation of sections/no discussion
1	Poor structure, minimal explanation, lack of discussion
2	Structured meeting, with explanations and time for issues to be considered and discussed

5. The facilitator explores, supports and encourages the user's expression of preferences.

0	Users preferences not explored beyond what has already been included on the menu prior to the meeting
1	Some exploration of preferences, but a lack of encouragement and support in response to hesitancy, or uncertainty in the user's views
2	The facilitator adequately explores, encourages and supports the user's expression of preferences

6. The facilitator will prompt members of the treatment team to offer their opinions on the implications of different treatment choices or decisions, and to suggest when alternative treatment choices may be available.

N/A	No necessity for prompting: the team engaged in active discussion due to active team discussing issues
0	The facilitator did not prompt members of the team or facilitate discussion
1	Partial use of opportunities for prompting and discussion
2	Good use of opportunities for prompting and discussion

7. The facilitator does not seek to influence the user's choices other than to help them identify possible outcomes or implications of treatment choices. They may however try to summarise and recapitulate the user's views to assist the user's decision making.

0	The facilitator clearly tried to influence the user's choices eg. "I think you should do that"
1	The facilitator made subtle or indirect attempts to influence the user's choices based on their opinion eg "sounds like a good idea to me", rather than reflecting back implications or outcomes for the user to consider
2	The facilitator did not seek to influence the user's choices

8. The facilitator will emphasise that what is included on the Joint Crisis Plan is decided by the user.

0	The facilitator did not explain that what is included on the JCP is the user's choice
1	The facilitator briefly mentioned, but did not emphasise that what is included on the Joint Crisis Plan is the user's choice.
2	The facilitator emphasised or repeated the point that what is included on the Joint Crisis Plan is the user's choice.

9. If there are initially opposing points of view between the user and treatment team about a statement/treatment choice/diagnosis, the facilitator will make efforts to ensure the reasons for the wishes of the user and the reasons for the advice of the team are understood by the other party. In the event of more than one area of disagreement give overall rating.

N/A	No disagreement occurred
0	Facilitator failed to explore the reasons for the user's wishes/teams advice
1	Facilitator partially explored the reasons for the user's wishes/team's advice but it was not clear that these were understood by the other party
2	Facilitator made adequate efforts to explore the reasons, so that it was clear that the wishes of the user and the advice of the team were understood by the other party.

- 10.If there are initially opposing points of view between the user and treatment team about a statement/treatment choice/diagnosis, the facilitator will facilitate negotiation between user and team to find a solution that is satisfactory to the user. In the event of more than one area of disagreement give overall rating.

N/A	No disagreement occurred
0	Facilitator did not negotiate, and instead wrote down the wishes of the user OR the team without further discussion
1	Facilitator negotiated but did not check that the final wording was satisfactory to the user
2	Facilitator negotiated, either reaching a satisfactory solution OR an agreement to differ that is explicit on the JCP/Crisis Card

- 11.If the treating team feel that they cannot agree with a treatment choice, the user will be advised that they can choose whether a statement to this effect can be included on the plan, or whether the plan will be re-named as a crisis card.

N/A	No disagreement occurred that was not resolved in a way satisfactory to the user
0	Facilitator did not introduce the options of an 'agreement to differ' on the JCP or renaming the plan a Crisis Card
1	Facilitator introduced the two options but did not fully explain them
2	Facilitator explained the two options so that the user could make an informed choice between them.

12. The wording of what is to be included on the card is checked with the user as each section is included, so that the preferred wording of the user may be used as much as possible.

0	The wording was never checked with the user
1	The wording was only checked with the user for some sections
2	The wording was checked with the user for all sections

13. Sufficient time was allowed by the treating team members to complete the process.

0	All the treatment team left the meeting before the whole content could be covered
1	All content was covered but the meeting felt rushed (e.g. discussion was cut off) OR some of the treating team left early
2	All content was covered and sufficient time was given to agree the content.

14. The facilitator established a good rapport with the service user listening and responding sensitively to their concerns. The quality of the rapport may also be evident from the user's response to the facilitator.

0	Very poor rapport/failure to listen and respond sensitively/ user left the meeting through dissatisfaction with the process
1	Some difficulties with rapport/listening and responding sensitively/user appears dissatisfied with the facilitator
2	Good rapport/listening and responding sensitively/user appears satisfied with the facilitator

15. The facilitator remained neutral and non-judgemental in their approach and negotiation with all parties

0	Very unbalanced in either the team's or the user's favour
1	Somewhat unbalanced in either the team's or the user's favour
2	Well balanced, neutral, understanding approach

16. At the end of the meeting the facilitator asked the clinical team whether they were in agreement/ could support the user's plan, and clarified that it should be called a Joint Crisis Plan. If agreement could not be reached the facilitator explained the implications and options available and made the outcome clear based on the user's wishes (ie. Crisis card, or Joint Crisis Plan with statement regarding specific area of disagreement).

0	The clinical team were not asked if they agreed with the user's plan
1	The clinical team were asked, but did not agree and the implications and options were not explained adequately and/or the outcome was not clear
2	The clinical team were asked if they agreed, and if they did not agree, the implications, options and outcome were established

Appendix P Example Memo

The following memo about making choices from the psychiatrist data eventually generated the category 'Influencing Choice' (see Section 10.3).

Making and allowing choice

This is really about promoting autonomy isn't it. As PL03 discusses. And the conflict between beneficence and autonomy.

It is this question about enabling good choices. But why does psychiatry have this power? An analogous situation in general medical is a forcibly determining a diabetics diet. One could argue that a diabetic has the information about their diagnosis, but chooses to eat that chocolate bar is making an unwise choice – is there any discourse about intervening? Perhaps there is, but perhaps it is the moral imperative here in psychiatry – the entitlement to act, the necessity to act that differentiates it. And I think this comes down to the issue of psychiatric power – that they have the power to intervene so they can. But should they? The implications of intervening and questioning service user's choices and enforcing a view or imploring a view, are potentially quite severe – the idea of disengagement at one end (yes yes doctor but then not following any recommendations) and at the other end is learned hopelessness or dependency – which the isn't sufficient resource to support....

Not all SU want choice – why is that? Is it a permanent state of affairs? Is it changeable – are there certain decisions they do want involvement in.

When I meet the patients, I explain to them what a consultant is. 'I am your consultant and am the person who you consult for expert advice. You are in charge'. It is more or less what I tell them. You come to see me and I am your expert. You're the king in this situation and I am your counsel. I will implore you, at times, to follow my advice like good counsellors would to previous kings and queens. But it is down to you. So that is how I practice anyway... so the intervention wasn't... different. (PL02)

However, what differs here from the king and counsel analogy is that the king has an unequivocal power to make decisions. The counsellor may implore the king, but the king has ultimate choice. The difference in mental health is clear. The psychiatrist has the power, and while they may say the service user has ultimate choice, while there is the mental health act, clinicians have the ultimate control and choice over a service user. Imploring, therefore, has a very different effect. PB04 seemed to realise that the power differential was hindering service users in disagreeing with him – he wanted more challenge in the JCP meeting. However, PL02 doesn't seem to understand this.

Whenever there is any medication changes I'll talk them through what I am thinking. I'll say, you've got this option and this option, and you now, there are a few others, and I'll go through them and I'll tell them what I would do, you know if it was me or one of my kids, I'd go with that for these reasons, but here's your choice. It gets them engaged in their care and if they are engaged in their care they are more likely to follow what I am recommending. (PL02)

But coming from allowing/or at least trying to enable service user choice is the notion of requiring service users to take responsibility for their actions – and supporting them if they fall, but having a system where it is not the doctor's fault if the service user relapses. This is an uncomfortable position for many doctors who do feel ultimately responsible for the well-being of the service user and for managing risk – and not just risk to self or others in terms of physical safety, but risk in terms of managing relationships and the whole gammet of life (PL01 for example). In this context, it is a difficult under-taking for doctors to allow ultimate choice that may be outside of current treatment guidelines or against the current evidence base. In this way, doctors appear to compromise by presenting some choice and interpersonally pressuring (e.g., imploring) the service user to take their advise. Or to only present some options – that they personally believe in. Accepting that they don't know everything.

PL02 – imploring SU to follow his advice and stipulating that this is a free choice. Applying pressure through 'imploring' limits the real choice that SU have. It creates a situation where if a SU was to not follow his advice, they would need to deal with his disappointment and disapproval. And from someone who has a great deal of authority and power over them, this is quite a challenging task to undertake.

How do we ensure that choices made by SU are free and full? What impact does Dr/CC advice have on this? If a doctor implores you to take his advice, would you? Would you feel able to say no?

Perhaps having the facilitator there preventing 'interpersonal' pressure from doctors? No evidence for this – but perhaps Sarah from L_NC_SU was getting there with the fact that doctors need a spot light on their behaviour. The facilitator provided a spotlight and therefore the interpersonal pressures were not used.

Could refer this to George's hierarchy of coercion – interpersonal pressure, leverage etc, versus coercion... Is this OK? Is it OK to pressure someone?

Providing choice

One of the clearest benefits for the JCP is that Dr talk about presenting options and making sure that SUs understand the possibilities available to them. And that this is not done very successfully in routine practice because they don't focus on crisis and detailed, individualised plans. Presenting a range of options helps provide a SU with a sense of real choice – and that they can make that choice – perhaps as opposed to Drs presenting limited options due to time limitations or strong views about the benefits of particular options.

PM01 admits that he hasn't facilitated patient choice in his routine practice because he sees the patients as too ill. Perhaps this is because he is a younger doctor??

Also admits that he doesn't always provide all the information to people regarding side effects – in this way he is heavily weighting the information he is providing as 'advise' or 'options' so that in fact the service user is unable to make informed choice.

However, he believes that they are not able to and some don't want to. And yes this is established in some research (Hamman on SDM I think) that some SUs don't want to engage in choice. However, is this learned helplessness? Should we be working in a way to ensure that SUs are involved.

PM02 – "its I who decide you know" (p6) – acknowledging that she consults with SUs but in the end it is her choice ultimately. She make the decision. I think she sees this as her role – her duty. Her role in her clinic is to gather information and

then decide what to do about it. This is a rather oldfashioned view of things. But she really understood the micro of the interaction in the JCP... so it shows the entrenched formula of doctor-patient relationships in terms of decision making. We now consult with SUs – we gather their views – but we still decide.

So both PM01 and PM02 state that they ultimately decide. PM01 gives justification that it is the nature of the illness. PM02 doesn't justify it is just a statement of fact. She understood the distinction between that and what the JCP was trying to do, but didn't apologise for her normal way of tackling things. She feels that this is her role.

Also PM03 talked about this in some ways, page 5 he is happy to keep in the community because of electronic linking... but he is the one who makes the decision. Dr Decides.

He believed that there is very little choice in psychiatry because his focus is 'macro'/systemic level. What choices other people are presenting are smaller, mx a or mx b, but he just sees step pathways perhaps because of his position, perhaps because of lacking resource so can't spend time going through minutiae of the small choices around.

Also he 'instructs' people to take his advice – and says you can't instruct people in the community – again focus is on macro process such as use of MHA as formal instruction – not understanding the 'take it' is an instruction on a micro level.

His supermarket analogy – the product on the shelf is on 'offer' as is his advice. However if customer doesn't take product from shelf they are in fact 'disagreeing' with the offer/ thinking it isn't right for them. So for the patient, not taking advice is a disagreement with the suitability of the advice.

This lack of understanding of the micro is influential in whether drs think JCP had an impact. Those who don't understand the micro will focus on whether the plan was used, accessible etc. Those who understand the micro, understand the JCP was about process and making detailed plans and spending time listening to plans – giving SU confidence that people understood and would implement plan – taking away a worry for them.

Appendix Q Approval for ethics amendments for qualitative work

Amendment 3: Addition of Psychiatrist interviews

King's College Hospital Research Ethics Committee
Camberwell Building
King's College Hospital
94 Denmark Hill
London
SE5 9RS

Tel: 020 3299 5033
Fax: 020 3299 5085

30 November 2009

Professor Graham Thornicroft
Head of Health Service and Population Research Department
Institute of Psychiatry
P029, De Crespigny Park, London
SE5 8AF

Dear Professor Thornicroft

Study title: CRIMSON Study: RCT of Joint Crisis Plans to Reduce
 Compulsory Treatment of People with Psychosis.
REC reference: 07/H0808/174
Amendment number: 3
Amendment date: 14 October 2009

The above amendment was reviewed at the meeting of the Sub-Committee held on 23 November 2009.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date	
Introductory letter for psychiatrist interviews	1	23 September 2009	
Participant Consent Form: Consent form for psychiatrist interviews	1	23 September 2009	
Participant Information Sheet: JCP Experience PIS	2	14 October 2009	
Participant Information Sheet: PIS for psychiatrist interviews	1	23 September 2009	
Protocol	9	23 September 2009	
Covering Letter		14 October 2009	

Notice of Substantial Amendment (non-CTIMPs)		14 October 2009	
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R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

07/H0808/174:
correspondence

Please quote this number on all

Yours sincerely

Miss Juliet Kirk-Buaku
Committee Co-ordinator

E-mail: Juliet.Kirk-Buaku@nhs.net

Amendment 5: Addition of Individual Interviews



National Research Ethics Service

NRES Committee London - Dulwich

(formerly South East London REC 3, formerly King's College Hospital Research Ethics Committee)
1st Floor Camberwell Building
King's College Hospital
94 Denmark Hill
London
SE5 8AF

Tel: 020 3299 39
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05 July 2011

Professor Graham Thornicroft
Head of Health Service and Population Research Department
Health Service and Population Research, Institute of Psychiatry
P029, De Crespigny Park
London
SE5 8AF

Dear Professor Thornicroft

Study title: CRIMSON Study: RCT of Joint Crisis Plans to Reduce Compulsory Treatment of People with Psychosis.
REC reference: 07/H0808/174
Amendment number: 5, May 2011
Amendment date: 08 June 2011

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter		24 May 2011
Participant Consent Form: Interviews - Service Users	3	24 May 2011
Participant Consent Form: Interviews - Staff	4	24 May 2011
Participant Information Sheet: Interviews - Staff	4	31 October 2007
Participant Information Sheet: Interviews - Service Users	5	24 May 2011
Protocol	11	24 May 2011
Notice of Substantial Amendment (non-CTIMPs)	5, May 2011	08 June 2011
Covering Letter		24 June 2011

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

07/H0808/174:

Please quote this number on all correspondence

Yours sincerely



Dr David Jewitt
Chair

E-mail: juliet.kirk-buaku@nhs.net

Enclosures:

List of names and professions of members who took part in the review

Copy to:

*Keith Brennan, King's College London
Simone Farrelly, IoP*

Patient Information Sheet
**CRIMSON study: A Study of Joint Crisis Plans to reduce compulsory
treatment for people with psychosis.**
Focus Groups – Service Users
(Version 4, 31 October 2007)

We would like to invite you to take part in focus groups as part of the CRIMSON study. Before you decide you need to understand why these focus groups are being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about taking part in the focus groups if you wish.

Ask us if there is anything that is not clear or if you would like more information – there are contact details at the end of page 2. Take time to decide whether or not you wish to take part.

You are invited to take part in a focus group (group discussion) as part of the CRIMSON study. The CRIMSON study is a trial of 'Joint Crisis Plans'. The Joint Crisis Plan is an agreement between you and your mental health team about what to do if you become unwell in the future. The focus group will help us understand your experiences and thoughts about the Joint Crisis Plan.

What is the purpose of the focus groups?

We want to find out whether having a Joint Crisis Plan

- affected your relationship with your care team;
- helped you to feel more involved in your treatment;
- was a positive or negative experience for you and why.

Why have I been invited?

You are being approached to take part in the focus group because you have developed a Joint Crisis Plan with your care team. You therefore may have views on whether the Joint Crisis Plan had any effect on you.

Do I have to take part?

No. If you decide not to take part, your care will not change in any way. Even if you decide to take part, you may leave the study at any time, without giving a reason

What will happen if I choose to take part?

If you agree to take part in the focus group, you will be asked to attend at least one focus group:

- one with other service users who also developed a Joint Crisis Plan;
- one with both other service users and Care Coordinators or other care team members so we can talk about how the process of developing and using a Joint Crisis Plan worked from different peoples' points of view. Your own care coordinator will be invited to the group and therefore it is important that you are comfortable with this idea before you decide if you want to be involved in the second focus group.

Each focus group will take between 1 and 1.5 hours to conduct. Each group will have between six to eight people. A member of the research team who is experienced in running focus groups will run them. That person will ask questions

regarding your experience of the Joint Crisis Plan. These groups will give you the opportunity to discuss your experiences and help the researchers to understand what worked and didn't work with your Joint Crisis Plan. The sessions will be tape-recorded so they can be typed up to make sure that there is an accurate record of the discussion.

Expenses and Payments

You will receive £20 for taking part in each focus group in recognition of the time and thought you have given to this study.

What are the possible risks of taking part?

Some people may find discussing their past experiences of illness or treatment distressing. You do not have to answer any questions that you do not feel comfortable answering.

What are the possible benefits of taking part?

You may or may not experience some benefit from taking part in these focus groups. These sessions may give you the opportunity to hear about other service users' and coordinators thoughts and experiences in a way that you may find helpful.

What if there are any problems?

If you are worried about any part of this study, please speak to the researchers who will do their best to answer your questions (contact details below). If you have complaints about the study you can complain formally through the NHS Complaints Procedure (details can be obtained from the Trust).

Will my taking part in the study be kept confidential?

All information collected about you will be kept strictly confidential to the study (unless it gives rise to concerns about your safety or that of other people). The focus group sessions will be typed up and then read and re-read by members of the research team. The tapes will then be destroyed. When reporting the findings of the study, we may use direct quotes from you. If so, we will give you a different name so that your identity is protected.

Any information about you that we store on computer will have your name and address removed so that you cannot be recognised. Written records of interviews will be stored in locked files in the researchers' office. All databases will be password protected. Information collected in the study will only be available to research staff and research regulators.

What will happen to the results of the research study?

Results from the study may be published in medical or psychiatric journals, without using any information that could identify patients.

Who is organising and funding the research?

This research is being run and organised by three groups: the Institute of Psychiatry, Kings College London; the University of Birmingham; and the University of Manchester. The research is funded by the Medical Research Council (MRC).

Who has reviewed the study?

This study has been reviewed and given favourable opinion by Kings College Hospital Research Ethics Committee.

Further information and contact details

If you have any questions regarding the study, please contact Professor Graham Thornicroft (Chief Investigator) on 0207 848 0735 or Ms. Simone Farrelly (CRIMSON Scientific Coordinator) on 0207 848 5098.

If you have specific questions about the focus groups, you may also like to contact the focus group leaders:

- Professor Helen Lester in Manchester on 0161 2757602
 - Dr Diana Rose in London on 0207 848 5066
-

Consent Form
CRIMSON study: A Study of Joint Crisis Plans to reduce compulsory
treatment for people with psychosis.
Focus Groups – Service Users
(Version 2, 31 October 2007)

Centre number:

Patient Identification number for this study:

Please tick each box

- | | | |
|----|---|--------------------------|
| 1. | I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. | I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my medical care or legal rights being affected. | <input type="checkbox"/> |
| 3. | I understand that my comments may be used in reports on this study and that these will be anonymous. I give permission for this. | <input type="checkbox"/> |
| 4. | I understand the focus groups will be tape recorded | <input type="checkbox"/> |
| 5. | I agree to take part in the above study | <input type="checkbox"/> |

_____ Name of Participant	_____ Date	_____ Signature
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_____ Name of Person taking consent (if different from researcher)	_____ Date	_____ Signature
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_____ Name of Researcher	_____ Date	_____ Signature
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Patient Information Sheet
CRIMSON study: A Study of Joint Crisis Plans to reduce compulsory treatment for people with psychosis.
Focus Groups – Staff
(Version 4, 31 October 2007)

We would like to invite you to take part focus groups as part of the CRIMSON study. Before you decide you need to understand why these focus groups are being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the focus groups if you wish.

Ask us if there is anything that is not clear or if you would like more information – there are contact details at the end of page 2. Take time to decide whether or not you wish to take part.

You are invited to take part in a **focus group (group discussion)** as part of the CRIMSON study. The CRIMSON study is a trial of 'Joint Crisis Plans'. The Joint Crisis Plan (JCP) consists of an agreement between service users and their mental health treatment staff. It states what should happen if they experience a crisis or become unwell in the future. The focus groups will help us understand your experiences and thoughts about the Joint Crisis Plan

What is the purpose of the focus groups?

We want to find out whether developing the Joint Crisis Plan

- affected your relationship with the service user;
- was a positive or negative experience for you and why.

Why have I been chosen?

You are being approached to take part in the focus groups because you were involved in developing a Joint Crisis Plan with a service user. You therefore may have views on what whether the Joint Crisis Plan is a helpful tool for service users and mental health teams.

Do I have to take part?

No. We will describe what will be involved in the focus groups and go through this information sheet with you and will invite you to sign a consent form to show you have agreed to take part.

What will happen if I chose to take part?

If you agree to take part in the focus group, you will be asked to attend at least one focus group:

- one with other Care Coordinators/ care team members;
- one group with service users and Care Coordinators or other care team members combined. Service users that you have worked with as a care coordinator will be invited to the group and therefore it is important that you are comfortable with this idea before you decide if you want to be involved in the second focus group.

Each focus group will take between 1 and 1.5 hours to conduct. Each group will have between six to eight people. A member of the research team who is experienced in running focus groups will conduct them. They will ask questions regarding your experience of the Joint Crisis Plan. These groups will give you the opportunity to discuss your experiences and help the researchers to understand what worked and what didn't work with Joint Crisis Plan from your perspective. The sessions will be taped so that they can be typed up.

Expenses

You will receive £20 for taking part in each focus group in recognition of the time and thought you have given to this study.

What are the possible risks of taking part?

You may not feel comfortable in answering questions about your experiences. If this is the case, you do not have to answer any questions that you do not feel comfortable answering.

What are the possible benefits of taking part?

You may or may not experience some benefit from taking part in these focus groups. These sessions may give you the opportunity to hear about other service users and care team workers thoughts and experiences in a way that you find helpful.

What if there are any problems?

If you are worried about any part of this study, please speak to the researchers who will do their best to answer your questions (contact details below). If you have complaints about the study you can complain formally through the NHS Complaints Procedure (details can be obtained from the Trust).

Will my taking part in the study be kept confidential?

All information which is collected about you during focus groups research will be kept strictly confidential. The focus group sessions will be typed up and then read and re-read by members of the research team. The tapes will then be destroyed. We may use direct quotes from you. If so, we will give you a different name so that your identity is protected. Information collected in the study will be stored in locked filing cabinets and on password protected databases and only be available to research staff and regulatory personnel, who may review documents as part of routine audits.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time. All you have to do is notify the researcher of your decision.

What will happen to the results of the research study?

Results from the study may be published in medical or psychiatric journals, without the use of any information that could identify patients.

Who is organising and funding the research?

This research is being run and organised by three groups across England: the Institute of Psychiatry, Kings College London; University of Birmingham; and University of Manchester. The research is funded by the Medical Research Council (MRC).

Who has reviewed the study?

This study has been reviewed and given favourable opinion by Kings College Hospital Research Ethics Committee.

Further information and contact details

If you have any questions regarding the study, please contact Professor Graham Thornicroft (Chief Investigator) on 0207 848 0735 or Ms. Simone Farrelly (CRIMSON Scientific Coordinator) on 0207 848 5098.

If you have specific questions about the focus groups, you may also like to contact the focus group leaders:

- Professor Helen Lester in Manchester on 0161 2757602
- Dr Diana Rose in London on 0207 848 5066

Consent Form
CRIMSON study: A Study of Joint Crisis Plans to reduce compulsory
treatment for people with psychosis.
Focus Groups – Staff
(Version 3, 29 July 2009)

Centre number:
XX Identification number for this study:

Please tick each box

- | | |
|--|--------------------------|
| 1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my medical care or legal rights being affected. | <input type="checkbox"/> |
| 3. I understand that my comments may be used in reports on this study and that these will be anonymous. I give permission for this. | <input type="checkbox"/> |
| 4. I understand the focus groups will be audio tape recorded | <input type="checkbox"/> |
| 5. I agree to take part in the above study | <input type="checkbox"/> |

_____ Name of Participant/Staff member	_____ Date	_____ Signature
_____ Name of Person taking consent (if different from researcher)	_____ Date	_____ Signature
_____ Name of Researcher	_____ Date	_____ Signature

Participant Information Sheet
CRIMSON study: A Study of Joint Crisis Plans to reduce compulsory
treatment for people with psychosis.
Psychiatrist Interviews
(Version 1, 23 September 2009)

We would like to invite you to take part in an interview as part of the CRIMSON study. Before you decide you need to understand why these interviews are being done and what it would involve for you. Please take time to read the following information carefully.

Ask us if there is anything that is not clear or if you would like more information – there are contact details at the end of page 2. Take time to decide whether or not you wish to take part.

You are invited to take part in an interview as part of the CRIMSON study. The CRIMSON study is a trial of 'Joint Crisis Plans'. The Joint Crisis Plan (JCP) consists of an agreement between service users and their mental health treatment staff. It states what should happen if they experience a crisis or become unwell in the future. The interview will help us understand your experiences and thoughts about the Joint Crisis Plan, which will enable us and to possibly tailor the intervention to assist in future implementation.

What is the purpose of the interviews?

We want to find out whether developing the Joint Crisis Plan

- affected your relationship with the service user;
- was a positive or negative experience for you and why.

Why have I been chosen?

You are being approached to take part in the interview because you were involved in developing a Joint Crisis Plan with a service user. You therefore may have views on what whether the Joint Crisis Plan is a helpful tool for service users and mental health teams.

Do I have to take part?

No. We will describe what will be involved in the interview and go through this information sheet with you and will invite you to sign a consent form to show you have agreed to take part.

What will happen if I chose to take part?

If you agree to take part in the interview, you will be contacted to arrange a suitable time. The interview will take approximately 30 minutes to conduct. The interview will be conducted by the CRIMSON Scientific Coordinator. You will be asked questions about your experience of and view regarding the Joint Crisis Plan intervention. You will have the opportunity to discuss your experiences and help the researchers to understand what worked and what didn't work with Joint Crisis Plan from your perspective. The sessions will be taped so that they can be typed up.

Expenses

We are unable to reimburse you for your time.

What are the possible risks of taking part?

You may not feel comfortable in answering questions about your experiences. If this is the case, you do not have to answer any questions that you do not feel comfortable answering.

What are the possible benefits of taking part?

You may or may not experience some benefit from taking part in these interviews. These sessions will give you the opportunity to let the research team know your views about the Joint Crisis Plan and to raise any concerns you may have.

What if there are any problems?

If you are worried about any part of this study, please speak to the researchers who will do their best to answer your questions (contact details below). If you have complaints about the study you can complain formally through the NHS Complaints Procedure (details can be obtained from the Trust).

Will my taking part in the study be kept confidential?

All information which is collected about you during the interviews will be kept strictly confidential. The interviews will be typed up and then read and re-read by members of the research team. The tapes will then be destroyed. We may use direct quotes from you. If so, we will give you a different name so that your identity is protected. Information collected in the study will be stored in locked filing cabinets and on password protected databases and only be available to research staff and regulatory personnel, who may review documents as part of routine audits.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time. All you have to do is notify the researcher of your decision.

What will happen to the results of the research study?

Results from the study may be published in medical or psychiatric journals, without the use of any information that could identify patients.

Who is organising and funding the research?

This research is being run and organised by three groups across England: the Institute of Psychiatry, Kings College London; University of Birmingham; and University of Manchester. The research is funded by the Medical Research Council (MRC).

Who has reviewed the study?

This study has been reviewed and given favourable opinion by Kings College Hospital Research Ethics Committee.

Further information and contact details

If you have any questions regarding the study, please contact Professor Graham Thornicroft (Chief Investigator) on 0207 848 0735 or Ms. Simone Farrelly (CRIMSON Scientific Coordinator) on 0207 848 5098.

Consent Form
CRIMSON study: A Study of Joint Crisis Plans to reduce compulsory
treatment for people with psychosis.
Psychiatrist Interviews
(Version 1, 23 September 2009)

Centre number:
Identification number for this study:

Please tick each box

- | | |
|--|--------------------------|
| 1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my legal rights being affected. | <input type="checkbox"/> |
| 3. I understand that my comments may be used in reports on this study and that these will be anonymous. I give permission for this. | <input type="checkbox"/> |
| 4. I understand the interviews will be audio tape recorded. I give permission for this. | <input type="checkbox"/> |
| 5. I agree to take part in the above study | <input type="checkbox"/> |

_____ Name of Participant/Staff member	_____ Date	_____ Signature
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_____ Name of Person taking consent (if different from researcher)	_____ Date	_____ Signature
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_____ Name of Researcher	_____ Date	_____ Signature
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Appendix S Topic guides for qualitative work

Service user Focus Group Topic Guide

Relationships with team

- What do you want from your relationship with your care coordinator? Your psychiatrist? What are your goals??
- Can you tell me of a time when you felt that CC/psychiatrist treated you well? What about a time they treated you less well?
- What about trust?
 - o Are there things that you won't tell your CC/psychiatrist about?
 - o How do you decide to what to tell your team about your experiences?
 - o Does your team trust you?

JCP

Do you remember why you wanted to make a Joint Crisis Plan? What was it about the JCP that appealed to you.

Process

Thinking back to when you made the JCP...

- What do you remember about the
 - o first meeting?
 - o Second meeting?
 - o Psychiatrist, CC during meeting
 - o Impact of the facilitator? Nurse – did that matter to you? Prefer another service user/ or someone else?
 - o Did these meeting differ from your normal meetings with CC/psychiatrist?

Content

- What did you think of the finished plan?
 - o What did you put on it and why?
 - o How much of it was your decision?
 - o Were you happy with it or are there things you would change?

Use

Since you developed the plan....

- How have you used it?
- How else have you used it?
- For those who were sectioned/went to hospital, did you use to the JCP? Did you refer to it? Did staff? What impact did it have?
- For those that were not sectioned/didn't go to hospital, did you use the JCP during this period? What impact did it have?

Impact

- What impact has JCP had your relationship with your psychiatrist? With your care coordinator? What about for *you*?
 - o What about communication?
 - o Decision making?
 - o Trust and disclosure
 - o Control
 - o Power
 - For those sectioned: Your team sectioned you under the Mental Health Act after making the JCP with you. How did this affect your relationships with your team?
 - For those not sectioned: Your team has the capacity to section you under the Mental Health Act. How does this affect your interaction with your team?

Care Coordinator Focus Group Topic Guide

Normal relationships and interactions

- What is the goal of your interactions with the service users?
 - o Are these the same goals as the service users?
- What is your role as a Care Coordinator?
 - o Can you give me an example of when your interaction with your service user worked well? What about less well?
 - o What factors influence your ability to perform your job well?
- Tell me about the relationship you have with service users?
 - o does this vary – what factors affect it
 - o What is a 'good' relationship? What about boundaries?
 - o Does trust come into this – in terms of winning trust of the user as well as trusting them for the information they provide
 - o How do you judge the extent to which a service-user is trustworthy (diagnosis eg PD – interactions – past experience with patients – more general interaction skills – implicit judgements)
 - o And would you say that service-users typically trust you (is trust often difficult to win – what factors might influence this)
 - o Are there specific things you try to do in order to build trust with the service-user (if so, what – what have you learnt in this regard over the course of your experience)
- What is discussed/done in your meetings with service user?
 - o How do you decide what to do?
 - o How do you make change happen?
- What is your responsibility in this relationship?
 - o What is the service user responsible for?
- What are your views on involving service users in treatment planning?
 - o How important is trust?

Joint Crisis Plans

Process

Thinking back to when you developed the plan with the Service User and the facilitator...

- What was your experience of developing the plan?
 - o First meeting?
 - o Second meeting?
 - o Service User, Doctor during meeting
 - o Impact of the facilitator?
- What was different about the planning meeting? What was the same?
- What did you think of the finished plan?
- If successful (i.e., we see a reduction in the use of the MHA), what do you think would be the barriers to implementing JCPs more widely in routine services?

Use

Since the plan was developed

- How have you used it
- For those with service users *who were sectioned*, how did you use the JCP at this time?
 - o What about the service user?
 - o Other staff?
 - o What impact did it have?
 - o What impact does sectioning someone have? What about trust and future disclosure?
- For those with service users *that were not sectioned*, how did you use the JCP during this period?
 - o What about the service user? Did they use it??
 - o Did other staff?
 - o If the JCP was used, what impact did it have?

Impact

- Thinking about the time since you developed the JCP with the service user, what impact has it had
 - o On your relationship?
 - o What about communication?
 - o What about engagement/other behaviour from Service User?
 - o Decision making?
 - o Trust and disclosure
 - What does trust mean to you?
 - How do you decide to trust your service user?
 - Positive risk taking
 - Impact of MHA on your relationship
- What do you think about your relationship with the service user not being equal in terms of power?
 - o Respect
 - o Perception of risk

Service User Individual Interview Topic Guide

Mental Health Services – Needs and Expectations

- What do you need from mental health services? Do they deliver this?
- How much control do you have over your life? Do services take over?
- Do you feel hopeful for the future?
- How are decisions made about your treatment usually? Are you told or involved?
- What do you think of your care plans?

What is it like for you when you become unwell? Is it something that you can predict?

Relationships

- Tell me about your relationship with your care coordinator? What about your psychiatrist?
 - o Are they your friends?
 - o How important to you are they?
- Can you tell me of a time when you felt that CC/psychiatrist treated you well? What about a time they treated you less well?
- What about trust?
 - o Are there things that you won't tell your CC/psychiatrist about?
 - o How do you decide to what to tell your team about your experiences?
 - o Does your team trust you?

Joint Crisis Plan

- Do you remember why you wanted to make a Joint Crisis Plan? What was it about the JCP that appealed to you?
- What about hope?

Process

- What do you remember about the
 - o first meeting?
 - o Second meeting?
 - o Psychiatrist, CC during meeting
- What did you think of the facilitator?
 - Were they there for you or for the services?
 - Nurse – did that matter to you? Prefer another service user/ or someone else?
- Did these meeting differ from your normal meetings with CC/psychiatrist?
- How much control did you have in that situation? Different?

Content

- What did you think of the finished plan?
 - o What did you put on it and why?
 - o How much of it was your decision?
 - o Were you happy with it or are there things you would change?

Use

Since you developed the plan....

- How have you used it?
- How else have you used it?
- For those who were sectioned/went to hospital, did you use to the JCP? Did you refer to it? Did staff? What impact did it have?
- For those that were not sectioned/didn't go to hospital, did you use the JCP during this period? What impact did it have?

Impact

- What impact has JCP had your relationship with your psychiatrist? With your care coordinator? What about for **you**?
 - What about communication?
 - Decision making?
 - Trust and disclosure
 - Control
 - Power
 - For those sectioned: Your team sectioned you under the Mental Health Act after making the JCP with you. How did this affect your relationships with your team?
-

Psychiatrist Individual Interview Topic Guide

1. Can you tell me about your impressions of the JCP meeting
 - a. How did it differ from your routine practice?
 - b. What impact did your presence have? Did you need to be there?
 - c. What were the productive/helpful aspects of the JCP meeting?
 - d. What were the least productive/helpful aspects of the JCP meeting?
2. What effect did the JCP intervention have
 - a. During the meeting i.e., did it change the way you interacted with the service user?
 - b. Since the meeting i.e., has there been a noticeable impact?
3. What do you think would be the barriers to implementing JCPs more widely?
 - i. Firstly in terms of completion? E.g., (team barriers – tick box mentality;
 - ii. Secondly in terms of use in a crisis?
 - b. What is a realistic way that this could be done?
 - c. How do you view the facilitator? Did they bring anything extra to the process?
 - i. Is it feasible for facilitators to this process? Could care coordinators be trained to do this?
 - d. What of the newly proposed commissioning arrangements – should there be budget for the JCP?
 - e. What sort of patient group would be best placed to make use of it and why?
Probe for issues of capacity and insight as well as type of service provision
4. We have spoken to service users who developed a plan 18 months after making their JCP and a lot don't remember it. What do you make of that?
5. How would you describe your individual relationships with service users in your care?
 - a. *(There has been a fairly consistent commitment to 'patient centered' practices – how would you define that? How does the JCP help to ensure PCentered practices?)*
 - i. How would you define a TR? How important is that in your practice?
 - b. What do you seek to do when you interact with service users? What is the goal of the interaction?
 - c. Who is responsible for SU's wellbeing?
 - d. Is your role to advise or instruct?
 - e. What are your views regarding service user involvement generally in treatment planning?
 - f. Is there a conflict between principle of beneficence and patient choice/autonomy?
 - i. Is patient choice/autonomy always a good thing?
 - g. What are your views on service users developing Advance Statements? What about your role in supporting this?
6. Demographics
 - a. Years practicing as a psychiatrist
 - b. Years as a consultant
 - c. Approximately how many service users do you have on your books?
 - d. How many sessions each week do you direct to: patient contact; administration; managerial tasks; research; other?

CC Individual interviews Topic Guide.

Roles and Goals

- What is the role of mental health services?
 - o *maintenance, crisis etc*
 - o has this always been the same?
- What is your role as a care coordinator?
- What is the goal of your interactions with the service users?
- What do service users want from you?
 - o Can you always deliver these?
 - Can you interact meaningfully in the time that you have?
 - What stops you from doing this?
 - What impact has restructuring had?
 - o Whose needs are prioritised?

Relationships and Responsibilities

- Tell me about the relationship you have with service users?
 - o does this vary – what factors affect it
 - o What is a 'good' relationship? What about boundaries?
- What are your needs in this relationship?
- What about trust?
 - o Do they trust you – how do you achieve this?
 - o Do you trust them? What factors influence this?
- What is your responsibility in this relationship?
 - o What is the service user responsible for?
 - o What about risk? How do you manage it? Does this impact on the relationship?

Care planning

- How important are care plans? Who are they for?
- What are your views on involving service users in treatment planning?
 - o What are the pros and cons of patient choice?

Joint Crisis Plans

Process

- What was your role in developing the plan?
- What was the impact of the facilitator?
 - o What was it like to have others involved in care planning?
- What was different about the planning meeting? What was the same?
- What did you think of the finished plan?
 - o Whose plan was it?

Use

Since the plan was developed

- How have you used it?
- For those with service users *who were sectioned*, how was the plan used at this time?
 - o What impact did it have?
 - o What impact does sectioning someone have? What about trust and future disclosure?

- For those with service users *that were not sectioned*, how did you use the JCP during this period?
 - o What about the service user? Did they use it??
 - o Did other staff?
 - o What impact did it have?

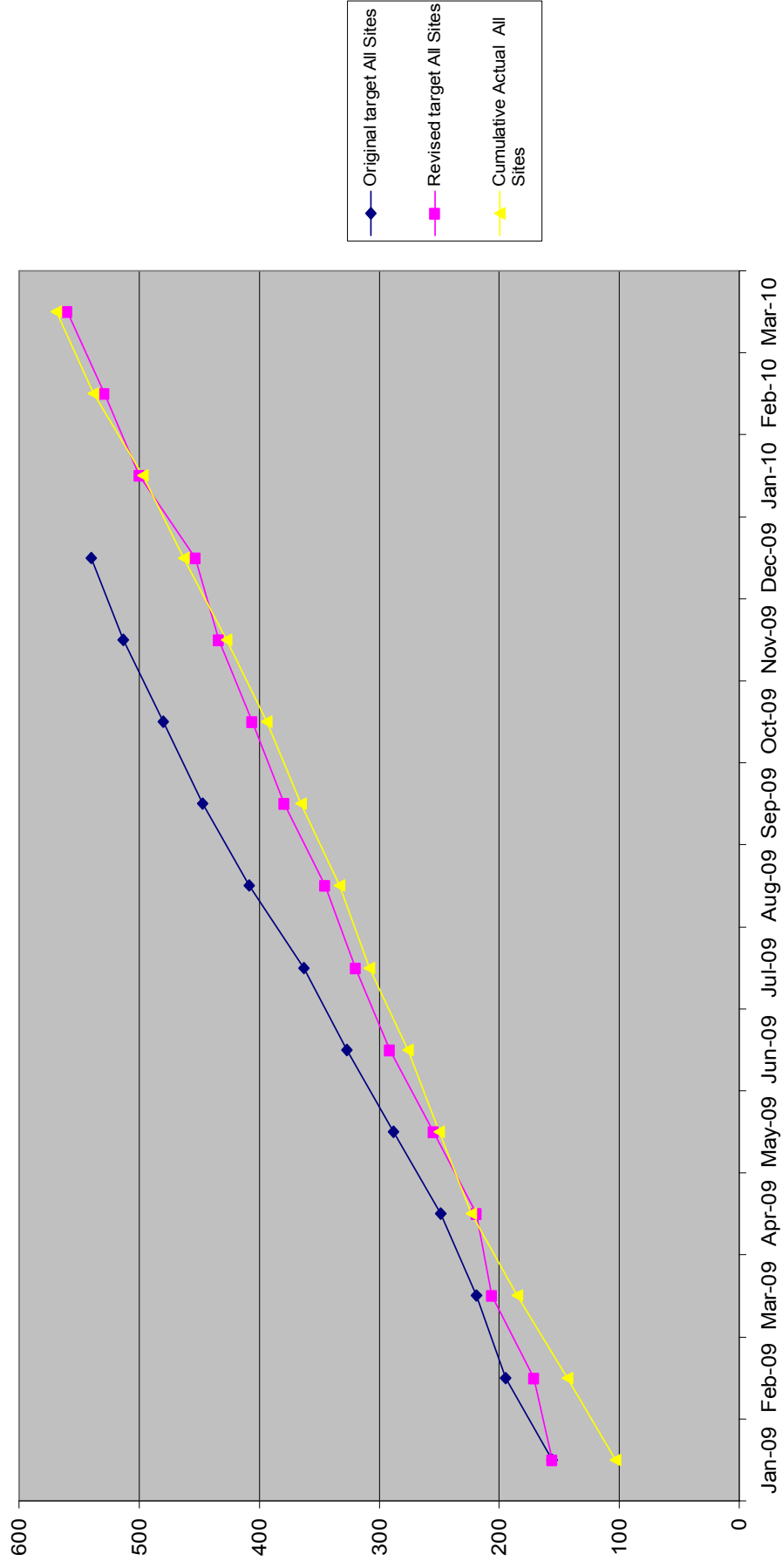
Impact

- Thinking about the time since you developed the JCP with the service user, what impact has it had
 - o On your relationship?
 - o What about engagement/other behaviour from Service User?
 - o Care planning? Decision making?

Appendix T

CRIMSON recruitment

CRIMSON Overall Recruitment performance



Appendix U Selection of JCP Menu headings

	Frequency of inclusion, n(%)					
Joint Crisis Plan subheading	CRIMSON		Pilot RCT		Pilot Study	
Nominee	184	83	65	100	33	82.5
Current care and treatment plan						
My mental health problem or diagnosis	219	99	65	100	38	95
Physical illnesses or allergies	122	55	25	38	14	35
Current care/treatment plan	207	94	65	100	31	77.5
Current medication and dosage	218	99	65	100	37	92.5
Circumstances that may lead to me becoming unwell or which have done so in the past	215	97	62	95	26	65
What happens when I start to become unwell	214	97	65	100	37	92.5
Treatments or other things that have been helpful during crisis or relapses in the past	205	93	62	95	31	77.5
Treatments or other things that have not been helpful during crisis or relapses in the past*	151	68	56	86		
Care in a crisis						
What I would like to be done when I start to become unwell	220	100	65	100	36	90
Preferred treatment or social care during a crisis or relapse	218	99	63	97	26	65
Specific refusals regarding treatment during a crisis or relapse	95	43	48	74	21	52.5
Circumstances in which I would wish to be admitted to hospital for treatment	171	77	64	98	28	70
Practical Help in a Crisis						
If I am admitted to hospital please contact the person named below and ask them if they would carry out the following tasks for me	132	60	55	85	21	52.5
If I am admitted to hospital I would like the following arrangements for my children/dependent relative	28	13	17	26	2	5
Agencies/people that I would like to have copies of JCP						
Myself	190	86	65	100	40	100
Treatment team	191	86	65	100	40	100
Emergency clinic/ A and E liaison team	0	0	41	63	34	85
Electronic Patient Record Systems**	175	79				
General Practitioner	143	65	57	88	29	72.5
Nominee	87	39	54	83	30	75
Other friends/family/professionals	40	18				
Other Information I would like to be known or taken into account **	69	31				

Notes: *missing data for pilot study; ** subheading not used in study

Appendix V Missing WAI data

Reason for missing WAI data

	SU data (n=569)		CC data (n=569)	
	Baseline	Follow-up	Baseline	Follow-up
Missing Total	3	123	43	123
Reason				
Declined to answer	3		41	17
Insufficient items to pro-rate	-	3	2	2
SU DNA follow-up interview	-	65	-	43*
Discharged	-	33	-	33
Not met CC/no CC	-	22	-	22
CC off long-term sick	-	-	-	4
SU not seen for > 3 months	-	-	-	2

Abbreviations: CC: Care coordinator; SU: Service User; DNA: Did not attend

Notes:

* Permission given by SU to collect from CC in 22 cases

Analysis of missing data at follow-up

Variable	Category Value	Missing WAI-SU at follow-up		
		No (n=446)	Yes (n=123)	P-value
Site	1. Birmingham	163 (84.9%)	29 (15.1%)	0.002
	2. London	153 (79.7%)	39 (20.3%)	
	3. Manchester/ Lancashire	130 (70.3%)	55 (29.7%)	
Sex	0. Male	226 (79%)	59 (21%)	0.56
	1. Female	220 (77.5%)	64 (22.5%)	
Age	0. 18-30 years	112 (80%)	28 (20%)	0.60
	1. 31-45 years	206 (79.2%)	54 (20.8%)	
	2. 46 years +	128 (75.7%)	41 (24.3%)	
Marital Status	Married / cohabiting	82 (72.6%)	31 (27.4%)	0.10
	Widowed/separated/divorced	799 (73.8%)	28 (26.2%)	
	Single	283 (81.8%)	63 (18.2%)	
	Other	2 (66.7%)	1 (33.3%)	
Living status	Alone	200 (79.7%)	51 (20.3%)	0.50
	Not alone	246 (77.4%)	72 (22.6%)	
Ethnicity	White-all	277 (78.5%)	76 (21.5%)	0.53
	Black/Black British - all	118 (80.3%)	29 (19.7%)	
	Other	50 (73.5%)	18 (26.5%)	
Education	School/None	351 (79%)	93 (21%)	0.41
	Vocational/Higher	93 (75.6%)	30 (24.4%)	
Grouped Diagnosis	Schizophrenia Spectrum disorder	333 (78.9%)	89 (21.1%)	0.61
	Affective disorders	113 (76.9%)	34 (23.1%)	
Number of previous admissions (2 years prior)	(median (IQR))	1 give means	1 (1-2)	0.005 *
Total duration of admissions- days (2 years prior)	(median (IQR))	62 (31-131)	54 (28 – 126)	0.52*
Functioning (GAF)	(median (IQR))	43 (37 – 51)	44 (35 – 53)	0.46*
Treatment experience survey	Perceived Coercion (median (IQR))	2.5 (1-4)	2.5 (1-4)	0.95*
	Negative (median (IQR))	3 (2-5)	4 (2-5)	0.43
	Voice (mean (SD))	1.44 (0.81)	1.4 (0.85)	0.62
Engagement	(median (IQR))	9 (4-14.5)	10 (5-15)	0.55*

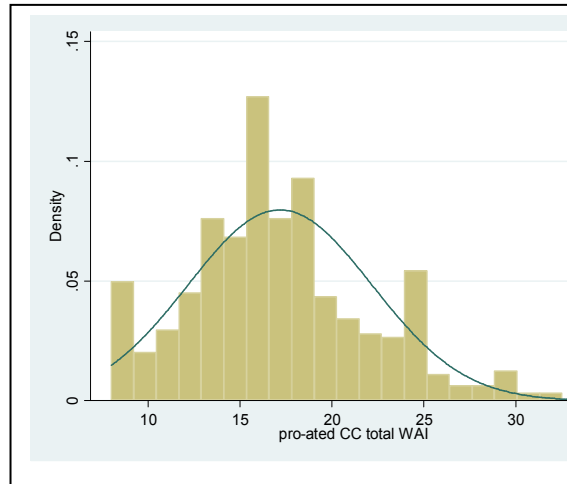
Abbreviations: SD: standard deviation; IQR: inter-quartile range; GAF: Global Assessment of Functioning.

Notes:

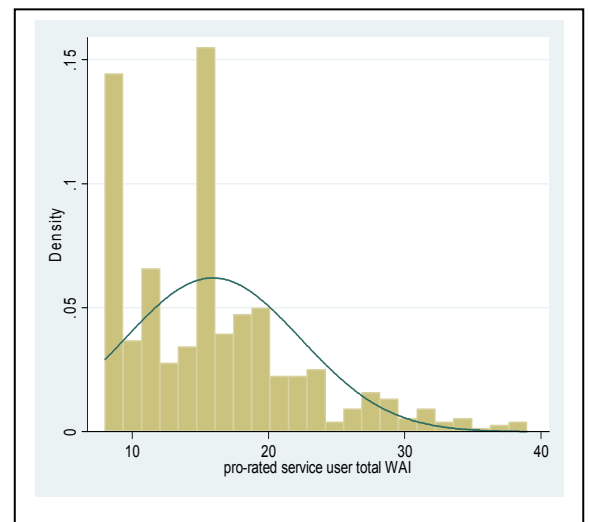
* non-parametric test used

Appendix W Distribution of dependent variables

WAI-CC Baseline



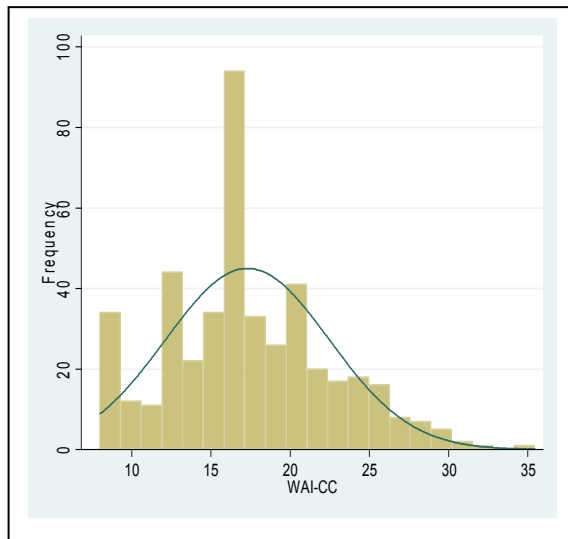
WAI-SU Baseline



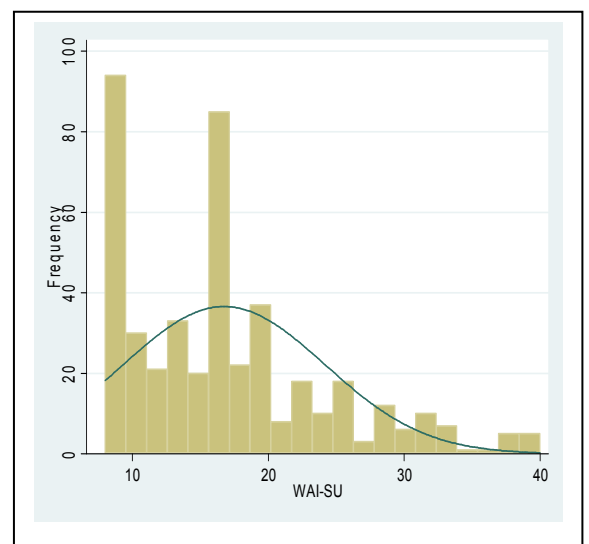
Summary statistics of WAI at baseline.

	N	Mean	Standard Deviation	Median	Min	Max	Skewness	Kurtosis
WAI-SU	566	15.91	6.43	16	8	39	0.96	3.90
WAI-CC	526	17.17	5.00	16	8	35	0.50	3.30

WAI-CC Follow-up



WAI-SU Follow-up



Summary statistics for WAI at follow-up

	N	Mean	Standard Deviation	Median	Min	Max	Skewness	Kurtosis
WAI-SU	446	16.74	7.41	16	8	40	0.92	3.49
WAI-CC	446	17.30	5.16	17	8	35.4	0.34	2.95